Coroners Act, 1996
[Section 26(1)]

Western  ***Australia***

RECORD OF INVESTIGATION INTO DEATH

Ref No: 7/2016

I, Rosalinda Vincenza Clorinda FOGLIANI, State Coroner, having investigated the death of ***Maureen Mandijarra****, with an Inquest held at Broome Court House, Hamersley Street, Broome on 22-25 February 2016 and at Perth Coroner's Court, Central Law Courts, 501 Hay Street, Perth on 12 April 2016, find that the identity of the deceased person was* ***Maureen Mandijarra*** *and that death occurred on 30 November 2012 at Broome Police Station corner Hamersley and Frederick Streets Broome from a cause that is unascertained (consistent with Streptococcus dysgalactiae and Staphylococcus aureus septicaemia in a woman with diabetes mellitus) in the following circumstances -*

Counsel Appearing :

Mr Toby Bishop assisted the State Coroner
Mr Paul Gazia and Mr Alexander Walters (Aboriginal Legal Service) appearing on behalf of Ms Pauline Mandijarra, sister of the deceased
Mr Brendan Slattery (instructed by Police Legal) appearing on behalf of the Commissioner of Police, Senior Constable Dan Colman, Sergeant Troy Kendall and Senior Sergeant Jason Van Der Ende.

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INTRODUCTION

1. In the early hours of the morning on 30 November 2012 Maureen Mandijarra (Ms Mandijarra) was found unresponsive by police as she lay on a mattress in Cell 4 at the Broome Police Station Lock-Up (the Lock-up). The police commenced CPR and called for an ambulance. Paramedics arrived, but tragically, Ms Mandijarra was unable to be revived.

2. Ms Mandijarra was 44 years old when she died. She had been arrested on the evening of 29 November 2012 and detained at the Lock-up, in connection with street drinking. She was heavily intoxicated when she was admitted into custody, as a result of consuming excessive amounts of alcohol. The police's plan had been to detain her overnight while she was intoxicated and to release her the following morning.

3. Police did not apprehend how fragile Ms Mandijarra's overall health was when they admitted her into custody. They were principally focussed on her intoxication. They thought that she would "sleep it off" overnight. However, Ms Mandijarra's health deteriorated overnight and she suffered a catastrophic collapse.

4. Ms Mandijarra's pre-existing conditions included poorly controlled diabetes. She also suffered from recurrent infections. The severity of these conditions was exacerbated by her alcoholism. At the time of her death she had nowhere to live and she was primarily itinerant. Her intoxication on the evening of 29 November 2012 was symptomatic of a more far-reaching decline in her health and social circumstances.

5. It was not always like that for Ms Mandijarra. She grew up in a close and loving relationship with family members, learning traditional skills from her siblings. She was educated at Balgo and later at a girls' school in Perth. She had an artistic talent and an alert mind. However, along the course of her life she suffered insurmountable loss and sadness. She entered a cycle of despair from which she was unable to extricate herself.

6. The trajectory of Ms Mandijarra's very tragic life and the death is evidenced by her numerous attendances at Broome Hospital, increasing in frequency in 2012. Her presentations to the Emergency Department predominantly related to

injuries from alleged assaults, alcohol related issues and recurrent infections. She would often leave the Emergency Department before she was seen or abscond from the ward shortly after admission resulting in her not completing her recommended treatment.

7. The frequency of Ms Mandijarra's admissions to the Broome Sobering-up Shelter also evidences the extent of her dysfunction. At the time of her death she had been banned from the Broome Sobering-up Shelter for a number of weeks, due to her aggressive behaviour on the occasion of her last attendance there.

8. The focus of the inquest into Ms Mandijarra's death was on the quality of her supervision, treatment and care while she was in the custody of the police from the time of her arrest at Male Oval in Broome on the evening of 29 November 2012 up until the time of her death in the early hours of the morning on 30 November 2012.

9. Ms Mandijarra's homelessness, her exposure to, and susceptibility to, infections, her co-morbidities, and her prior contacts with the health and justice systems were also explored. These factors are inextricably connected with, and reflect upon, the complexities that were involved in addressing her welfare and her safety.

MS MANDIJARRA

10. Ms Mandijarra was born on 28 October 1968 at Halls Creek. In terms of cultural identity, Ms Mandijarra was a Kukatja woman on her father's side and a Jaru woman on her mother's side. During her earlier years, she had lived at the Balgo Aboriginal Community and in Alice Springs. Ms Mandijarra was the youngest of six children. She had two older brothers and three older sisters who loved her dearly. As a child she spent a lot of time with them, and they had taught her traditional skills that included hunting and fishing.

11. Very sadly Ms Mandijarra lost her mother at a young age. She had four children of her own. Tragically she lost her second child to meningitis. She accumulated many stressors in her life. Over a period of time, she began to misuse alcohol,

undoubtedly to self-medicate or cope with her sadness, but inevitably to her severe detriment.

12. At the time of her death she had become separated from her community at Halls Creek and had moved to Broome. The deleterious impact of the loss of contact with family and community cannot be underestimated. In Broome she was unemployed and she became homeless. She struggled physically and emotionally. Her alcoholism became so severe that she was unable to adequately self-care.

13. Shortly before her death she was living on the streets of Broome and in the sand dunes behind the Broome Police Station. She sometimes slept outside the Broome Visitor Centre and on Male Oval. A profoundly concerning but sadly predictable consequence of her homelessness was that it exposed her to the risk of interpersonal violence and injury.

14. Ms Mandijarra had a history of frequent attendances at Broome Hospital for a range of conditions aggravated by her alcoholism and her inability to manage her diabetes. Some were related to alcohol-fuelled assaults. On occasion she sought accommodation at the Broome Sobering-up Shelter. These were temporary measures, and in isolation they could not address the complexities of her dire circumstances.

15. Shortly before Ms Mandijarra's death the local community members had noted that she had increased her alcohol intake. She was in a relationship but very sadly it was marred by acts of domestic violence. By the time of her death her body bore the scars and abrasions of a person who had been repeatedly injured, either by assault, accident or self-inflicted injury.

16. The tragedy of Ms Mandijarra's life is in contrast to the promise that she showed as a young child. She attended schools in Balgo and in Perth. By all accounts she was a bright and happy student. As she grew into adulthood she demonstrated her unique talents as an artist and for a time she worked in that capacity for the Wiyilli Community Art Gallery.

17. Inevitably, Ms Mandijarra's alcohol consumption and homelessness led to a cascade of incidents that repeatedly brought her to police attention, though it is to be noted that her own offending was primarily of a low-level nature. The police officers who gave evidence at the inquest recalled her

from their interactions with her over time. Ms Mandijarra was considered to be usually co-operative. The sergeant in charge of the overnight shift at the Lock-up spoke of Ms Mandijarra's characteristic sense of humour and he recalled that by her wit and banter she was able to bring some constables "*down to earth with a great thud.*"[1]

18. Numerous witnesses attested to Ms Mandijarra's engaging personality when she was sober. Undoubtedly Ms Mandijarra had an inner strength and an artistic sensitivity. Very sadly she was unable to escape a cycle of alcohol abuse and violence. These factors shaped her behaviours and experiences towards the latter part of her life. Her tragic death was a loss to her family, and to the community.

THE INQUEST

19. Ms Mandijarra's death was a reportable death within the meaning of s 3 of the *Coroners Act 1996* (the Coroners Act) and it was reported to the coroner as required by s 17 the Coroners Act.

20. Pursuant to s 19(1) of the Coroners Act I have jurisdiction to investigate Ms Mandijarra's death. The holding of an inquest, as part of the investigation into her death, is mandated by reason of s 22(1)(a) of the Coroners Act. This is because immediately before death Ms Mandijarra was a person held in care by reason of being under the control, care or custody of members of the Police Force, namely members of the Western Australia Police Service (the police).

21. I held an inquest into Ms Mandijarra's death and heard evidence from 14 witnesses between 22 to 25 February 2016 and on 12 April 2016. I received 5 exhibits into evidence, comprising as follows:

a) Exhibit 1, tabs 1 to 16;
b) Exhibit 2, tabs 1 to 22;
c) Exhibit 3, tabs 23 to 42;
d) Exhibit 4, tabs 43 to 53; and
e) Exhibit 5, tab 1 to 20

22. My primary function has been to investigate Ms Mandijarra's death. It is a fact-finding function. Pursuant to s 25(1)(b)

[1] ts 90

and (c) of the Coroners Act, I must find, if possible, how Ms Mandijarra's death occurred and the cause of her death.

23. Pursuant to s 25(2) of the Coroners Act, in this finding I may comment on any matter connected with Ms Mandijarra's death including public health, safety or the administration of justice. This is the ancillary function.

24. Pursuant to s 25(3) of the Coroners Act, because Ms Mandijarra was a person held in care, I must comment on the quality of her supervision, treatment and care while in the control, care or custody of the police. This obligation reflects the community's concern about the treatment of those who are deprived of their liberty.

25. Section 25(5) of the Coroners Act prohibits me from framing a finding or comment in such a way as to appear to determine any question of civil liability or to suggest that any person is guilty of an offence. It is not my role to assess the evidence for civil or criminal liability, and I am not bound by the rules of evidence.

26. Pursuant to s 44(2) of the Act, before I make any finding adverse to the interests of an interested person, that person must be given the opportunity to present submissions against the making of such a finding. After the evidence was taken at the inquest, submissions were provided to me for the purposes of s 44(2) of the Act, between 10 May and 17 June 2016.

27. In making my findings I have applied the standard of proof as set out in *Briginshaw v Briginshaw* (1938) 60 CLR 336 per Dixon J at 361 - 362 which requires a consideration of the nature and gravity of the conduct when deciding whether a matter has been proved on the balance of probabilities.

28. In the conduct of the inquest, and for the purposes of discharging my functions under s 25(2) and s 25(3), I have taken account of the need for a thorough and independent judicial investigation of deaths in custody, as outlined by Royal Commissioner Johnston QC in the *Royal Commission into Aboriginal Deaths in Custody (1991)* (RCIADIC), conscious of the potential for me to identify systemic failures which, if acted upon, may prevent future deaths in similar circumstances.

29. I adopt the views expressed by Watterson R, Brown P and McKenzie J, *Coronial Recommendations and the Prevention of Indigenous Death* (2008) 12 (SE2) Australian Indigenous Law Report (6):

> "*The Royal Commission recommended an expansion of a coronial inquiry from the traditional narrow and limited medico-legal determination of the cause of death to a more comprehensive, modern inquest; one that seeks to identify underlying factors, structures and practices contributing to avoidable deaths and to formulate constructive recommendations to reduce the incidence of further avoidable deaths. The Royal Commission provides a timeless reminder that every avoidable Indigenous death calls upon us to identify its underlying causes, consider Indigenous disadvantage, uncover the truth about the death and resolve upon practical steps to prevent others.*"

30. My findings appear below.

PRIOR INTERACTIONS WITH HEALTH AND JUSTICE SYSTEMS

Attendances at Broome Hospital

31. Medical records reflect Ms Mandijarra's numerous attendances and admissions to Broome Hospital. She had a long history of alcohol abuse and she had been diagnosed with type II diabetes. She had been prescribed metformin, metoprolol, atorvastatin and aspirin.[2]

32. Throughout 2012 Ms Mandijarra presented to the Emergency Department of Broome Hospital (ED) with injuries and infections. She was often treated with antibiotics but she frequently failed to complete treatment or left ED before she could be seen by a clinician. The details of her attendances in the months prior to her death appear below and are relevant to an examination of the deterioration in her health and the complexities involved in addressing her health needs.

October 2012

33. On 7 October 2012 Ms Mandijarra presented to ED with a lacerated lip after an alleged assault. This was sutured and she did not require admission.

[2] Exhibit 1, tab 4

34. The laceration on her lip became infected and one week later on 14 October 2012 she re-presented to ED. She was commenced on IV antibiotics and an admission was planned for surgical review the following day. However she absconded that day, before she was reviewed.

35. Ms Mandijarra re-presented to ED on 15 October 2012, intoxicated. The infection on her lip was noted to have improved, and she was provided with an oral course of antibiotics.

November 2012

36. On 13 November 2012 Ms Mandijarra presented to ED with an abscess on her right lower leg. She was admitted to hospital for incision and draining of the abscess. She was administered intravenous antibiotics. During a discussion with the pharmacist, she disclosed that she did not take any of her prescribed medications for her diabetes and also, that she had not been attending the Broome Aboriginal Medical Services. Following discussions, she agreed to see the diabetes educator the following day. However, she absconded before this could be arranged.

37. Blood tests on that occasion showed a mildly raised CRP of 12 (<10) (which is a marker of inflammation), mild anaemia with a haemoglobin of 114 (115-160 g/L), normal white cell count and normal kidney function. *Staphylococcus aureus* (a common cause of wound infection) was grown on a wound swab of her right shin. This infection was sensitive to flucloxacillin (an antibiotic).

38. Three days later on 16 November 2012 at 7.19 am Ms Mandijarra presented to ED and requested that her right shin dressing be changed. It was noted that her wound was discoloured and odorous. Her blood glucose level was noted as normal. She did not wait to be seen. She returned to ED shortly afterwards at 8.40 am but again did not wait to be seen. There were no subsequent presentations to ED.

39. Just under two weeks later on 29 November 2012 police arrested Ms Mandijarra at Male Oval in Broome. One of Ms Mandijarra's friends had seen her vomit what appeared to be blood earlier that day, but Ms Mandijarra did not subsequently attend hospital. There is no information as to

the quantity of the vomitus or the blood, and police were not informed of this.[3]

Ms Mandijarra's health in 2012

40. Over the course of Ms Mandijarra's numerous attendances at Broome Hospital, swabs were taken in respect of a number of her injuries. During 2012 her wounds often showed the presence of S*taphylococcus aureus* and *Streptococcus pyrogenes* (group A). Approximately two weeks before her death, she received some treatment for a wound that showed the presence of S*taphylococcus aureus*. However, despite the fact that this wound was obviously troubling her, she did not wait to be seen when she returned to the ED.

41. It is clear that Ms Mandijarra suffered recurrent infections, and none of them truly resolved. Her non-compliance with medical treatment, her poorly controlled diabetes and her chronic alcohol consumption compounded the severity of her illnesses and compromised her ability to recover. Her homelessness affected her capacity to self-care and presented yet another challenge to the overwhelming accumulation of factors that combined to place her in a particularly fragile state of health in November 2012.

Referral to Kimberley Community Drug Service Team

42. Ms Mandijarra had a number of referrals to the Kimberley Community Drug Service Team.

43. Records from the Indigenous Diversion Program reflect that on 3 August 2012 Ms Mandijarra had been assessed at Broome Magistrate's Court as suitable for referral to the Community Drug Service Team. She did not attend her appointment on 8 August 2012 with the Community Drug Service Team. Numerous attempts at locating her over the next few weeks were unsuccessful.[4]

44. Ms Mandijarra would undoubtedly have been assisted by the Kimberley Community Drug Service Team, but that assistance could not be rendered if she did not engage with it. It is possible that her chronic alcohol consumption and

[3] Exhibit 2, tab 1; Exhibit 3, tab 29
[4] Exhibit 2, tab 1; Exhibit 3, tab 36

homelessness compromised her ability to make and keep appointments. She may also have been unwilling to participate.

Attendances at Broome Sobering-up Shelter

45. The Broome Sobering-up Shelter was formed after the RCIADIC, with the aim of providing a place for intoxicated people to receive shelter and assistance, instead of being taken into police custody under protective custody arrangements.

46. Residents can stay overnight at the Broome Sobering-up Shelter and there are half hourly checks to monitor welfare. Records reflect that the majority of the overnight residents are from Fitzroy Crossing, with some residents also from Halls Creek and Balgo. Attendances can be seasonal. Often, though not always, the Broome residents who are intoxicated are able to access the assistance of family members instead of utilising the Broome Sobering-up Shelter.[5]

47. The Broome Sobering-up Shelter staff members accept self-referrals or referrals from external agencies, often the police. Residents are assessed by staff members on presentation. They are subject to a voluntary breath test which is usually recorded. Staff members request that residents take a shower and they supply them with fresh clothing. Staff members wash the residents' clothing and provide them with food and a clean bed. Strict rules govern the establishment, that is there must be no bad manners or swearing at staff members and no violence of any sort.[6]

48. Ms Mandijarra's most recent visits to the Broome Sobering-up Shelter prior to her death were as follows:

    a) On 16 November 2012 police referred her to the Broome Sobering-up Shelter. She had been apprehended intoxicated in the streets of Broome and she was received into the Broome Sobering-up Shelter at approximately 7.20 pm. Her preliminary breath test was 0.309% BAC, a dangerously high level. She was provided clean pyjamas and a shower and after spending the night she left at 5.30 am on 17 November 2012.

[5] Exhibit 3, tab 34
[6] Exhibit 2 Tab 1, Exhibit 3 Tab 34

b) On 19 and 20 November 2012 she presented to the Broome Sobering-up Shelter of her own volition in the evenings on both dates. No breath test was recorded on those occasions.

c) On 21 November 2012 she presented to the Broome Sobering-up Shelter of her own volition at 8.30 pm. No breath test was recorded. The records reflect that she was discharged 20 minutes later at 8.50 pm and was subsequently banned until 5 December 2012 for refusing to have a shower and go to bed. She appears to have had an altercation with a person there, and to have left voluntarily.[7]

49. Records reflect that since August 2009 Ms Mandijarra had attended at the Broome Sobering-up Shelter on just over 140 occasions. The Broome Sobering-up Shelter provides commendable assistance to residents, and its operations are to be supported and encouraged. However, of necessity, the Broome Sobering-up Shelter cannot provide an ongoing and longitudinal assistance to residents, even those who attend on many occasions, such as Ms Mandijarra.[8]

50. The Broome Sobering-up Shelter's staff members had become acquainted with Ms Mandijarra as a result of her attendances. The Broome Sobering-up Shelter's manager recalled that staff members retained positive memories of Ms Mandijarra. As an overnight resident, she was known to be compliant. Her non-compliant behaviour at the Broome Sobering-up Shelter on 21 November 2012 was unusual for her.

Interactions with Police in 2012

51. The police officers who gave evidence at the inquest knew Ms Mandijarra from their day to day interactions with her in Broome, and also from her contact with the justice system. The contact invariably arose in connection with incidents precipitated by her chronic alcohol consumption, and risks to her safety and welfare exacerbated by her homelessness.

52. A review of Ms Mandijarra's records reflects numerous charges and most of those were in connection with alcohol

[7] Exhibit 2, tab 1; Exhibit 3, tab 34
[8] Exhibit 2 Tab 1

related offences. It is also apparent that in the months before her death, there was an escalation in her contact with the justice system, as the alleged victim or perpetrator.[9]

53. On 21 May 2012 a 72 hour police order was served upon a person after that person and Ms Mandijarra were seen grappling with each other on a street corner, both visibly alcohol affected.

54. On 25 May 2012 Ms Mandijarra was seen by a member of the public to be assaulting a person with a stick. She was interviewed by police and charged with aggravated assault occasioning bodily harm.

55. On 9 June 2012 at approximately 8.00 pm Ms Mandijarra was arrested at Kennedy Hill for disorderly conduct and failing to obey an order given by a police officer. She was released to bail shortly after midnight on 10 June 2012. She was also served with a move on notice.

56. On 26 July 2012 at 12.55 pm Ms Mandijarra was arrested on a warrant for a breach of bail and failing to appear in court and was released at 2.20 pm.

57. On 6 October 2012 at about 8.00 pm Ms Mandijarra was hit to the face by a person, requiring sutures to her lip. She reported the matter at Broome Police Station on 8 October 2012 and a person was arrested and charged on 14 November 2012 with aggravated assault occasioning bodily harm.

58. On 16 November 2012 Ms Mandijarra was arrested at Male Oval for breaching a move on notice. She had previously been issued that notice for repeatedly consuming alcohol at that location. She was conveyed to the Lock-up and she requested release to the Broome Sobering-up Shelter. She was released a short time later and was bailed to appear at Broome Magistrates' Court on 26 November 2012.

59. Shortly after her release (on 16 November) of her own volition Ms Mandijarra admitted herself to the Broome Sobering-up Shelter at 7.20 pm and this was the occasion where, as described above, she volunteered a breath test, which recorded a reading of 0.309% BAC.

[9] Exhibit 2, Tabs 1 and 7

60. On 25 November 2012 a person was seen with Ms Mandijarra, in breach of the protective bail conditions following the aggravated assault occasioning bodily harm allegedly committed on 6 October 2012. The person was arrested and charged with breach of protective bail conditions.

61. At approximately 7.00 am on 28 November 2012 Ms Mandijarra was arrested for failing to appear in the Broome Magistrates' Court. She was conveyed to the Lock-up where she was admitted to custody and kept in a cell for between one to two hours, pending her court appearance. She was released to SERCO at approximately 9.00 am on that date for the purpose of her court appearance.

62. The next evening, Ms Mandijarra was arrested at Male Oval, and the morning afterwards, she was found unresponsive in Cell 4 of the Lock-up.

ARREST ON 29 NOVEMBER 2012

Zero tolerance approach

63. Ms Mandijarra's arrest at Male Oval on the evening of 29 November 2012 needs to be seen within the context of the Broome police's zero tolerance approach to street drinking at that time.

64. Street drinking does not usually result in arrest and detention in a lock-up. However, at the material time, that did occur in Broome for street drinking. Where a person, usually quite apparently intoxicated, was observed to be consuming alcohol in a public place without the consent of the occupier (say a street, a park or a reserve) in circumstances where the Broome police officer reasonably suspected that if the person was not arrested, s/he would continue to consume the alcohol at that place, the discretion to arrest would be considered. The legal framework for arrest and detention for street drinking is addressed later in this finding.

65. Senior Sergeant Van Der Ende was the officer-in-charge of Broome Police Station between 2011 and 2013. He introduced the zero tolerance approach to a range of offending, including street drinking.

66. At the material time, Senior Sergeant Van Der Ende had been with the Western Australia Police Service for 20 years. Upon

taking up his role at Broome Police Station he analysed the available crime statistics for the area and decided to target what he identified as "*volume crime*" (burglary, stealing) and the violence that was being committed within the Broome sub-district.[10]

67. When Senior Sergeant Van Der Ende's analysed those crime statistics that involved violence, he readily identified that alcohol was a contributing factor. As part of his role, on a yearly basis he was required to create and implement the Broome Police Station Action Plan. At the inquest he was questioned in respect of the Action Plan that he created for the 2012 to 2013 year: "*Policing Plan priorities: Alcohol and drug harm, Antisocial behaviour, Illegal and antisocial road use, Violence and at At-Risk Youth*". It was very similar to the one he had created for the previous year.[11]

68. As part of the Action Plan Senior Sergeant Van Der Ende implemented a requirement to the effect that the policing team achieve at least ten visits per week to "*crime hot-spots*". He identified Male Oval in Broome as one of the hot-spot areas. The Action Plan also reflects that the police were to adopt the expectations of the agency, the officer-in-charge and the community. That was an expectation of "*zero tolerance*" towards anti-social behaviour and alcohol related offending.[12]

69. At the inquest Senior Sergeant Van Der Ende explained that in practical terms, it meant he expected police officers not to turn a blind eye to street and reserve drinking (both referred to in this finding as street drinking). He wanted police officers to engage with the problem and do something about it, rather than driving past and ignoring it on the basis that it is a minor offence.[13]

70. To assist Broome police officers in implementing the zero tolerance approach at the material time, after consultation Senior Sergeant Van Der Ende provided them with a flow chart to guide or assist their decision making in respect of suspected alcohol related offending.

71. In connection with street drinking, if a repeat offender was observed to be intoxicated, the flow chart indicated there was to be an arrest, with bail conditions, and options included

[10] ts 178
[11] Exhibit 5, tab 3; ts 178 - 179
[12] Exhibit 5, tab 3
[13] ts 179 - 180

taking the person home, to the Broome Sobering-up Shelter or admission to the Lock-up. If a person had a history of violence when intoxicated, the flow chart indicated there was to be an arrest, admission to the Lock-up, and release when sober, with bail conditions. They were not requirements, and police officers retained their individual discretion as to what action to take at all times.[14]

72. Senior Sergeant Van Der Ende's explanation was that if the person observed to be street drinking was a repeat offender, it meant that s/he had not responded to the liquor infringement notice process and therefore, in accordance with the flow chart, arrest was to be considered. In these circumstances, if the person was intoxicated, bail would be refused and the person would be admitted to custody, until police were satisfied that s/he was able to understand the bail conditions, and did not present a risk to themselves or another person. This would ordinarily occur when the person was observed to be sober.[15]

73. In practical terms, for overnight detentions it meant that the detainee would be expected to "*sleep it off*" at the Lock-up and then be released at a reasonable hour when s/he appeared to be sober, with bail conditions requiring them to appear in court in connection with the offence. At the inquest, Senior Sergeant Van Der Ende described police officers routinely tipping out alcohol at Male Oval, and outlined the reasoning behind the arrest of repeat offenders as follows:

> *"The way I looked at it, it was pointless if we're going out and writing the same people an infringement day after day after day, especially if they've got nowhere in town that they're living, they've got no means of paying an infringement and it's not changing the behaviour that we're trying to get to".*[16]

and:

> *"….if they're dealing with the same person day, day, day, doing the same thing, that's where they start building up that picture. Does this person have a significant issue with alcohol? Is their behaviour deteriorating, escalating? Do we need to take some action?"*[17]

74. Underpinning Senior Sergeant Van Der Ende's approach was his plan to stop street drinking earlier in the day in order to prevent alcohol-fuelled violence escalating later in the

[14] Exhibit 1, tab 14
[15] ts 183 - 184
[16] ts 185
[17] ts 186

evening, and therefore to process persons in respect of a relatively minor offence with the aim of stopping the serious offending.[18]

75. Senior Sergeant Van Der Ende presented the court with statistics that showed that as at 24 June 2012, following the implementation of the Action Plan and flowchart guidance, for Broome there was an overall decline in reported offences in the order of 24%, an 18.7% decline in reported domestic assaults and 23.3% decline in reported non-domestic assaults. There was however a 20% increase in reports of threatening behaviour, but it appears that the threats were not escalating into assaults.[19]

76. The decision to arrest for street drinking remained an individual matter for the arresting officer. The steps that Senior Sergeant Van Der Ende implemented were well known amongst the Broome police officers, and were referred to as the zero tolerance approach. He did not specify the number of infringements that were required to be had before a person was to be treated as a repeat offender with respect to street drinking.

77. Ms Mandijarra was arrested by Mr McDonald (then a First Class Constable) on 29 November 2012. He had been a member of the Western Australian Police Service for approximately seven years and had been stationed at Broome for between seven and eight months. At the inquest I explored the effect that the zero tolerance policy had on the exercise of his discretion to arrest Ms Mandijarra on 29 November 2012.

78. Mr McDonald confirmed that at the material time, he was aware of the zero tolerance approach to alcohol consumption in public places. During the period that he was stationed at Broome Police Station, he observed Broome to be "*plagued*" with alcoholism and alcohol-fuelled violence, domestic violence, and anti-social behaviour.[20]

79. Mr McDonald was aware that the proactive police response, which was to operate alongside alternative measures, was instituted in an attempt to stop re-offending. He believed that the plan was to arrest for simpler offences rather than wait for more serious offences to be committed. He was mindful of the

[18] ts 188
[19] Exhibit 4, tab 46; ts 187 - 188
[20] ts 14

fact that he retained the discretion as to whether to arrest or pursue an alternative option.[21]

80. At the material time, Mr McDonald was aware that there had been numerous incidents at Male Oval involving assaults and domestic violence. In his experience, most of these offences were directly tied to alcohol consumption, and if persons were heavily intoxicated, offending could escalate.[22]

81. As Mr McDonald understood it, the plan was not merely to arrest people for drinking in a park. The arrest would also be informed by other factors such as general unruly behaviour and the number of past offences, which would suggest that past prevention methods were not working.[23]

82. Constable Wright was with Mr McDonald when Ms Mandijarra was arrested on 29 November 2012. He was also aware of the zero tolerance approach. He had been a member of the West Australian Police Service for approximately six and a half years, and had been stationed in Broome for just under four years, having previously been stationed at Geraldton.

83. Constable Wright considered that at the material time Male Oval was a dangerous place and that an intoxicated person ought not to be left there. He did not consider that a move on notice would have been effective. In his experience, intoxicated persons did not generally comply with move on notices, and they might go on to commit offences by breaching them.[24]

84. Constable Wright's understanding of the zero tolerance approach was that if a person had numerous drinking infringements, then they were "*instructed*" to arrest and put bail conditions in place. Whilst he could not remember if there was a set number of infringements he himself believed it to be around two to three infringements.[25]

85. Taking the totality of the evidence into account, I am satisfied that the issuance of general guidance in respect of a zero tolerance approach to street drinking through the Action Plan was within Senior Sergeant Van Der Ende's remit, and that the reasoning behind it was well known by Broome police.

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[21] ts 16
[22] ts 39
[23] ts 14-16
[24] ts 332-333
[25] ts 332 - 333

86. Whilst I accept that the police officers were left with discretion as to how to apply the zero tolerance approach in given circumstances, on an individual level they treated it as quite firm guidance on what to do. This may have been affected by the issuance of the flow chart. The evidence at the inquest served to show that extreme care needs to be taken if it is proposed to issue a flow chart guiding an arrest, as it runs the risk of being interpreted as prescriptive.

Arrest at Male Oval

87. On 29 November 2012 Ms Mandijarra was at Male Oval on the Broome Highway adjacent to the central business district of Broome. She was sitting with a group of people and drinking alcohol. At about 6.45 pm Mr McDonald and Constable Wright were in a police vehicle conducting a patrol of the area.

88. They located Ms Mandijarra drinking alcohol in a public place, namely on the reserve known as Male Oval (that is, allegedly street drinking). Mr McDonald placed her under arrest and both officers conveyed her to the Lock-up. At the inquest I explored the circumstances surrounding Ms Mandijarra's arrest that evening.

89. Mr McDonald testified that on 29 November 2012 he was working the afternoon shift with Constable Wright. When he approached Male Oval in the police vehicle, he observed a group of people (two males and two females). His attention was drawn to the group because the two females were shouting at each other. As the police vehicle drew closer, the females stopped shouting and the group became quiet.

90. On his approach, Mr McDonald had observed Ms Mandijarra (who was known to him) sitting up and drinking from a white cup. As he walked over to the group he saw Ms Mandijarra move to lie on the ground and as he arrived she appeared to be sleeping. It was clear that she was not actually asleep.

91. Mr McDonald confirmed the substance in the white cup to be alcohol. From his interactions with Ms Mandijarra and his observations he formed the opinion (correctly as it transpired) that she was heavily intoxicated. She was the only person from the group that he observed consuming alcohol.[26]

[26] ts 11 - 13

92. While Mr McDonald was speaking with Ms Mandijarra, Constable Wright performed a check, identified a number of past liquor infringements for Ms Mandijarra and informed Mr McDonald. As a result of that information, his own observations of Ms Mandijarra that evening and his prior interactions with her, Mr McDonald formed the view that she was intoxicated, she was a repeat offender, and likely to keep consuming alcohol if not arrested. He formed the view that it may result in the escalation of offences. He took account of the pro-active approach regarding alcohol-related offences that was being encouraged. He therefore decided to arrest Ms Mandijarra. She was only person arrested from the group.[27]

93. Mr McDonald informed Ms Mandijarra that she was under arrest for "*park drinking*." He instructed her to get into the back of the police vehicle and she complied. He recalled that there was no need to touch her in order to convey her to the police station. Mr McDonald testified that he did not administer a breathalyser test when he arrested Ms Mandijarra because in his view blood alcohol readings do not always allow for an ascertainment of the level of intoxication because each person metabolises alcohol differently.[28]

94. At the inquest Mr McDonald was informed that Ms Mandijarra had been observed by a friend to have vomited what appeared to be blood earlier that day. He confirmed that he did not know this at the time of her arrest. He clarified that had he known, he would have asked her additional questions, informed the Sergeant, and probably have taken her to hospital.[29]

95. At the time of her arrest, Mr McDonald was not aware that Ms Mandijarra had diabetes, but he was aware of some of the previous conditions listed on the police information system, including her depression and risk of self-harm. He was not aware that a few weeks prior to her arrest she had presented to Broome Hospital and been diagnosed with an infected wound on her right lower leg.[30]

96. Constable Wright also gave evidence concerning the arrest at the inquest. He could not recall if he heard the shouting that

[27] Exhibit 2, tab 8; ts 32
[28] ts 17 and 32
[29] ts 34
[30] ts 35

drew Mr McDonald's attention to Male Oval, nor whether Mr McDonald told him why they were entering Male Oval. When Mr McDonald first got out of the police vehicle to speak to the group of persons on Male Oval, he had his head down doing paperwork and therefore did not observe the behaviour of the group.

97. When Constable Wright got out of the police vehicle (shortly afterwards) he recognised Ms Mandijarra (who was known to him). He saw Mr McDonald pour out some alcohol from a can of beer. At this stage he observed that Ms Mandijarra was lying on the ground. He did not observe anybody drinking. He proceeded to tip out two bottles of rum and a mug of alcohol.

98. He recalled hearing Mr McDonald informing Ms Mandijarra that she was under arrest for drinking alcohol. He observed two bottles of wine under a blanket that Ms Mandijarra was holding and a mug containing alcohol near her head as she lay on the ground.

99. Constable Wright testified that he agreed with Mr McDonald's decision to arrest Ms Mandijarra, in light of the zero tolerance approach.

ADMISSION TO CUSTODY ON 29 NOVEMBER 2012

100. When they arrived at the Broome Police Station at approximately 7.00 pm on 29 November 2012, Constable Wright's role was to admit Ms Mandijarra to custody. This required him to undertake a welfare screening for Ms Mandijarra and to enter relevant information about her into the police's electronic information system known as the Custody system.

101. Constable Wright asked Ms Mandijarra a number of questions related to her health and welfare. Ms Mandijarra uncharacteristically refused to answer his questions and became uncooperative. In accordance with established practice, he continued the process of her admission to custody and conveyance to the cell at the Lock-Up. At the inquest I explored the circumstances surrounding Ms Mandijarra's admission to custody on the evening of 29 November 2012.

102. It was relevant to contrast this custody admission with the one the day before, on the morning of 28 November 2012. On that prior occasion, Ms Mandijarra was compliant, calm and responsive to the questions concerning her welfare. Records reflect that on 28 November 2012, Ms Mandijarra was recorded as having no physical injuries. She was recorded as suffering dizziness and fainting spells and of having advised that she was a non-insulin dependent diabetic. She also advised that she suffered from depression and had previously thought about self-harm (these were added as warnings on her electronic records). She was released within a matter of hours.[31]

103. However, during her admission on 29 November 2012 Ms Mandijarra was agitated and her behaviour was erratic, reflecting not only her high level of intoxication, but perhaps also a degree of confusion brought on by her deteriorating health. Her welfare screening began shortly after she was brought into the charge room at approximately 7.00 pm. Mr McDonald and Constable Wright were both present throughout her admission to custody.

104. Ms Mandijarra's answers to Constable Wright's questions relating to her health and welfare were aggressive and non-responsive to the issue. She did not provide the requested information. At one point in the charge room she began to remove her clothing, despite repeated requests from the police officers to stop doing so. She was not known to have behaved in this manner on previous occasions.

105. Sergeant Kendall, the shift supervisor, was observing the custody admission from a remote CCTV camera and upon seeing Ms Mandijarra's behaviour, attended at the charge room to attempt to calm her. He found her to be quite irate and he recalled that this was the worst state he had seen her in. He formed the view that she was heavily intoxicated based on her actions and speech. He did not apprehend that she was unwell (save for her intoxication) and she did not mention any health concerns to any of the police officers.

106. At one point in Sergeant Kendall's presence Ms Mandijarra said "*I'll kill myself today*". Sergeant Kendall had heard Ms Mandijarra make such statements previously, and then retract them. He believed this was another such instance. Another warning was entered onto the Custody system for her

[31] Exhibit 2 Tab 1; Exhibit 5, tab 5

admission on 29 November 2012 to the effect that Ms Mandijarra had a history of self-harm.[32]

107. Sergeant Kendall made the decision that Ms Mandijarra was not to be released to bail that night. Due to her intoxication, he formed the view that she was unable to understand and therefore to comply with bail conditions, and that if released she was likely to get into an argument, with consequential risks to her or another's safety.

108. During her admission into custody, Constable Wright did not observe any injuries on Ms Mandijarra's body, other than a small scar on her lip. He testified that he had no concern about her health any more so than he would have for any other intoxicated person.[33]

109. Constable Wright cannot recall reading any previous warnings concerning Ms Mandijarra on the police's information management system (IMS), which at the time was not wholly integrated with the Custody system. He was required to assesses the risk level to Ms Mandijarra's welfare and enter it into the Custody system. He testified that he rated her as "*high risk*" due to her behaviour.

110. Constable Wright's entry onto the Custody system read: "*Increased Risk: Intoxicated and agitated* (sic)". He believed that Ms Mandijarra was being detained by Sergeant Kendall because she was not sufficiently sober to understand the bail conditions and her safety was at risk.[34]

111. The records reflect that Ms Mandijarra had been registered some 38 times in police custody and had a total of 27 warnings listed against her name on the IMS. A brief outline of her warnings is as follows:

- *VERY HIGH Caution – Suffers from depression;*
- *VERY HIGH Talk of self-harm;*
- *VERY HIGH May inflict self-injury;*
- *HIGH Has medical condition requires prescribed drugs;*
- *HIGH May carry a weapon (knife/club)*
- *MEDIUM Medical Condition requires regular monitoring;*
- *MEDIUM May suffer epileptic fits; and*

[32] Exhibit 5, tab 8; ts 111
[33] ts 337
[34] ts 342-343

- *MEDIUM May resist arrest and Alcoholic.*[35]

112. Constable Wright's evidence was that had he known of the number of warnings relating to depression and talk of self-harm, it may have changed the process that he undertook. If those concerns were heightened there was an option of placing Ms Mandijarra in a padded cell, not giving her a blanket and increasing the frequency with which she would have been monitored. He did not implement these options. Constable Wright's explanation was that in his experience, the vast majority of detainees have similar warnings.[36]

113. At approximately 7.15 pm Mr McDonald placed Ms Mandijarra into Cell 4 at the Lock-up. There were two other female persons already in that cell. They recalled Ms Mandijarra talking to herself, moving around the cell and alternately lying down. The tenor of their evidence is consistent with Ms Mandijarra being intoxicated and confused.[37]

114. The two females were released approximately ten minutes after Ms Mandijarra was placed in Cell 4. They did not observe any sign of her being unwell, and in the circumstances, I would not expect any such observation to have been made given the limited contact with her.

CELL WELFARE CHECKS AND RECORD KEEPING

115. Ms Mandijarra was in the custody of the police at the Lock-up from 7.00 pm on 29 November 2012 until she was found unresponsive in Cell 4 at approximately 4.30 am on 30 November 2012. During the period of her detention, police were required to undertake regular cell welfare checks for Ms Mandijarra, in order to ensure her safety and welfare and to determine any reasonable needs.

116. When conducting a cell welfare check (cell check) in respect of a sleeping detainee at the Lock-up, the Broome police's usual practice was to look for a sign of life, such as the rise and fall of the chest. Whilst this practice was acceptable in respect of a detainee who was in a reasonable state of health, it was clearly inadequate for a detainee such as Ms Mandijarra, who

[35] Exhibit 2, tab 20; the first two assessments had been entered the day before, 28 November 2012
[36] ts 338
[37] ts 66 - 77

was at risk of a cardiorespiratory arrest due to her high levels of intoxication and her co-morbidities.

Cell Check requirements in November 2012

117. In order to assess and comment on Ms Mandijarra's supervision, treatment and care at the Lock-up, it was necessary to identify the police procedures regarding cell checks and record keeping, as they applied in Broome in November 2012.

118. The evidence established that compliance with the cell check and record-keeping requirements set out in the Western Australia Police Service Manual (WAPOL Manual) was the primary obligation. In addition, compliance with the more specific cell check requirements of the Broome Police Station Lock-up Procedures (Broome Manual), tailored to the conditions in Broome, was expected by management in Broome.

119. In the context of this inquest, the material differences between the two manuals were:

a) the Broome Manual specified the time intervals between cell checks; and

b) the Broome Manual specified that a physical cell check could not be conducted via CCTV camera.

The details of both manuals' cell check requirements as at November 2012 appear below.

120. At the material time, the WAPOL Manual contained the following relevant provisions concerning the frequency of cell checks and the recording of those checks by police officers [extracts]:

> *"LP10-1 Cell Checks/Health, Safety, Welfare*
>
> *A member shall regularly visit each detainee to ensure the safety and welfare of that detainee and to determine any reasonable needs.*
>
> *Officers should be fully cognisant of the antecedents of detainees and ensure due caution is taken with detainees who are aggressive, dangerous or mentally unstable.*
> *……."*

"LP-10.3 Records of Checks and Observations

Members conducting cell checks shall record the time of each check and their observations of each detainee.

The type of cell check that is appropriate for each detainee will depend on the past history of the detainee, if known, and the information available and assessment made, at the time of admission. All information is to be recorded on the detainee running sheet and Custody.

A cell check may include physical arousal of an apparently unconscious detainee if this is necessary to ensure health and safety. Methods of arousal should be restricted to:

- *shaking;*
- *noise (calling out)*
- *pinching with fingers in web of hands or feet; and*
- *watching for the rise and fall of the chest.*

If there are any doubts about the condition of a detainee, or if a detainee fails to respond to these arousal techniques – SEEK MEDICAL ASSISTANCE IMMEDIATELY."[38]

121. The WAPOL Manual had required a police officer to "*regularly visit*" each detainee to ensure their safety and welfare, leaving the intervals between visits (that is, cell checks) to individual discretion depending on the circumstances of the detainee. However, the Broome Manual specified a set of minimum standards for the conduct of and frequency of cell checks at the Broome Lock-up [extracts]:

"5.3.1 The following minimum standards apply to cell checks and supervision at Broome Lock-up.

5.3.2 A physical check is to be conducted on every prisoner in the Broome Lock-up every 15 minutes for the first 2 hours and half hourly thereafter. Dependent upon the history and behaviour of the prisoner, the frequency of cell checks may need to be increased and may include constant physical supervision.

5.3.4 A physical cell check shall consist of the officer physically visiting the Lock-up to check on the prisoner and may include entering the cell if that is what is required to establish the welfare of the prisoner. Consideration shall be given to the safety of all persons when conducting such checks.

5.3.5 Cell Checks will be recorded on the Custody system.

[38] Exhibit 1 Tab 1

5.3.6 Entries on the Custody System shall be used to record all movements and visits relating to the prisoner.

5.3.7 ….

5.3.8 Viewing a prisoner via the cell camera monitors in the main office area may be done in between cell checks but observing a prisoner using this method will not constitute a cell check for the purpose of these procedures."[39]

122. The Broome Manual also contained provisions in relation to drunken detainees who were apprehended under the *Protective Custody Act* 2000. Whilst Ms Mandijarra was not apprehended under this legislation, paragraph 5.8 of the Broome Manual remains relevant:

"5.8.2 Officers shall only detain a drunken person in Broome Lock-up when:

- *It is in the interest of the safety and welfare of the detainee;*
- *No other person or facility is available to accept and care for the detainee."*

"5.8.5 Officers shall release a detainee within 8 hours of apprehension, except:

- …
- …
- *If the release of the detainee between the hours of midnight and 7.30am is not in the best interests of the detainee."*[40]

123. At the inquest I heard varying evidence regarding the extent to which the more specific cell check requirements of the Broome Manual were known of, and/or understood by the Broome police officers. The specification of a time interval between cell checks had the effect of providing for a more rigorous cell check procedure for Broome. The time intervals were inserted as a result of outcomes of prior coronial inquests.

[39] Exhibit 2 Tab 20
[40] Exhibit 2, tab 20

124. Senior Sergeant Van Der Ende had tasked one of the police officers to draft the Broome Manual, and he was therefore fully conversant with its requirements. A copy of the Broome Manual was circulated by email to police officers stationed at Broome on 11 February 2012, with an instruction to the effect that it be complied with. Detective Sergeant Kendall and Senior Constable Colman were responsible for Ms Mandijarra's cell checks between 29 and 30 November 2012. They were named recipients on the email, along with numerous others. The email also stated where hard copies of the Broome Manual could be found. Given the breadth of the circulation, I am satisfied that adequate steps were taken to disseminate the information as to the Broome Manual's requirements, and it was clear that compliance was expected.[41]

125. Most of the police officers who gave evidence at the inquest were aware that there were some requirements concerning the frequency of cell checks, though evidence varied as to what was understood of the time intervals. The Broome Manual also required that these be "*physical*" cell checks, meaning that checking for a detainee's safety and welfare by remote CCTV camera would not comply. This proscription was not so well known. The details are below.

126. Detective Sergeant Kendall was the shift supervisor in charge of Broome Police Station between 2.00 pm to 10.00 pm on 29 November 2012. He had the responsibility for cell checks of detainees over that period. At the inquest his evidence was that while he now believed that Ms Mandijarra was supposed to have been given a physical cell check every 15 minutes for the first hour (in fact it was for the first two hours), his practice at the material time was to continually monitor detainees through the CCTV camera.[42]

127. Detective Sergeant Kendall testified that he was able to observe detainees through the CCTV camera screen that was visible from his workstation. The camera allowed him to see inside the cells. His explanation was that he was usually too preoccupied with other tasks to conduct cell checks in person. He was not the only police officer to cite workload as an impediment to the proper conduct of physical cell checks.[43]

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[41] ts 190; Exhibit 5, tab 20
[42] ts 96
[43] ts 96; Exhibit 1, tabs 9 and 11

128. At the material time Detective Sergeant Kendall believed that remote cell checks were appropriate because in his opinion the remote viewing capabilities through the CCTV camera were quite advanced, allowing him to observe the rise and fall of a detainee's chest. At the inquest Detective Sergeant Kendall conceded he is now aware that this practice was incorrect.[44]

129. At 10.00 pm on 29 November 2012, Detective Sergeant Kendall handed over the shift supervisor's responsibilities to Senior Constable Colman, who was on night shift duty from 10.00 pm that night until 6.00 am on 30 November 2012, and assumed responsibility for the cell checks for that period. As part of his handover Senior Constable Colman was informed that Ms Mandijarra was highly intoxicated and needed to sleep.[45]

130. At the material time, Senior Constable Colman believed that the WAPOL Manual was applicable and that this required cell checks to be conducted every 30 minutes, with some of them needing to be physical cell checks. He also believed that more regular cell checks were required for a high-risk detainee. He was not aware of the Broome Manual's requirements.[46]

131. At the inquest Senior Constable Colman testified that after Ms Mandijarra's death he reviewed the Broome Manual and was "*quite shocked*" that it required 15-minute cell checks for the first two hours and half hourly checks thereafter. The reason for his reaction was twofold. He could not recall having previously reviewed the Broome Manual, and he did not believe, in light of workloads, that it would be practicable to conduct such checks.[47]

132. Senior Constable Colman was aware that there was an alert on the Custody system on 29 November 2012 regarding Ms Mandijarra's health and welfare. Records reflect that the entry stated: "*Increased Risk: Intoxicated and aggitated* [sic]". There was also a warning to the following effect: *"HAS SELF HARM HISTORY"*. Previous warnings, including from the day before, were expressed as: "*VERY HIGH*", with the entries: "*Caution – Suffers from Depression"* and "*Talk Of Self-Harm*".[48]

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[44] Exhibit 1, tab 9; ts 96-97
[45] Exhibit 2, tab 10
[46] ts 265
[47] ts 265
[48] Exhibit 5, tabs 4 and 8; ts 271

133. Whilst Senior Constable Colman could not recall the specific terms of the alerts that he viewed on the Custody system for Ms Mandijarra, based upon alerts and handover information, at the material time he was of the understanding that Ms Mandijarra had been classified as "*high risk*". Ordinarily, this would cause him to increase his level of monitoring for a detainee.[49]

134. However, Senior Constable Colman believed that the high risk classification was due to the behaviour that Ms Mandijarra was exhibiting upon admission to custody, as opposed to any inherent risk to health due to her level of intoxication. He formed the opinion that once Ms Mandijarra was asleep, that risk classification was no longer relevant.[50]

135. Senior Constable Colman was aware that a physical cell check required the police officer to go to the cell and observe the detainee physically. If the person appeared to be asleep, his practice was to look for the rise and fall of the chest. If this could not be ascertained from observation though the cell door's viewing pane he would enter the cell.[51]

136. At the inquest, in contrast to Detective Sergeant Kendall's evidence, Senior Constable Colman testified that in his experience it was not possible to observe the rise and fall of the chest from the remote CCTV camera, unless the detainee was breathing deeply.[52]

137. Detective Sergeant Kendall and Senior Constable Colman bore responsibility for the proper conduct of cell checks for Ms Mandijarra during their respective shifts. Other Broome police officers were also questioned about their knowledge of cell check requirements, and their answers referred to below reflected upon the awareness of the cell check requirements in Broome at the material time.

138. Mr McDonald (who placed Ms Mandijarra in Cell 4 at approximately 7.15 pm, and placed another female detainee into Cell 4 at approximately 11.00 pm) believed that a physical cell check was required every 15 minutes for the first two hours, and thereafter every 45 minutes. He recalled being shown the Broome Manual as part of his induction, and believed the requirements to be consistent with the WAPOL

[49] ts 270 - 272
[50] ts 281
[51] ts 281
[52] ts 268

Manual. He was not tasked with responsibility for cell checks for Ms Mandijarra at the material time.[53]

139. Mr McDonald had understood that the physical cell check required the police officer to walk to the cell, observe the prisoner through the viewing pane for signs of life, such as rise and fall of the chest or movement, and if need be, enter the cell and rouse the detainee to ascertain their welfare. He was of the understanding that both physical and remote cell checks were undertaken in 2012.[54]

140. Whilst not tasked with the responsibility for cell checks for Ms Mandijarra, at the material time Constable Wright believed that cell checks were to be performed around every 20 minutes, and that they were ether physical or remote cell checks. It was not usually part of his role in 2012.[55]

141. From Constable Wright's perspective physical checks involved actually going to the cell and looking for signs of life and this generally involved observing the rise and fall of the chest. He conceded that it would be unlikely that a detainee could be observed to be breathing from the remote CCTV screens, unless they were breathing very deeply.[56]

142. I am satisfied that at the material time, in addition to the WAPOL Manual requirements, the Broome Manual requirements concerning cell checks were applicable, and needed to be complied with. This meant that at a minimum, a physical check was to have been conducted for Ms Mandijarra every 15 minutes from 7.15 pm to 9.15 pm and every 30 minutes after 9.15 pm, until the time for her release. Compliance would not be achieved by conducting these cell checks through the remote CCTV camera that showed vision of the inside of Cell 4.

143. I am satisfied that by reason of both the WAPOL Manual and the Broome Manual, the police officers conducting the physical cell checks were required to make a record of the time of the check and enter their observations of Ms Mandijarra on the Custody system, on each occasion.

[53] ts 22 - 23
[54] ts 23 and 44
[55] ts 344 - 345
[56] ts 344-345

144. I do not accept that there was a failure to circulate or disseminate the Broome Manual to police officers at the Broome Police Station.

Workloads and Cell Check compliance in November 2012

145. As I have outlined above, the Broome Manual's cell check requirements stipulated the interval between checks, in contrast to the WAPOL Manual's requirement to "*regularly visit*" a detainee, as appropriate. The obligation to regularly visit was interpreted as affording more flexibility.

146. At the material time there was no dedicated Lock-up keeper at Broome Police Station. Accordingly, the police officer responsible for cell checks was routinely tasked with other duties when there were detainees in the Lock-up.

147. At the inquest, I received evidence relating to the Broome police officers' ability to perform cell checks every 15 minutes for the first two hours and half hourly thereafter, having regard to their workloads.

148. Sergeant Kendall gave evidence to the effect that Broome police station was the busiest workplace he had encountered in 20 years as a policeman, and that in November 2012 it was difficult to comply with the Broome Manual's cell check requirements because of the limited number of staff members at his disposal.[57]

149. The usual staffing levels for an afternoon or night shift comprised the shift supervisor, a telephone operator, a computer-aided dispatch (CAD) system operator to allocate policing tasks and dispatch police vehicles, a designated Lock-up keeper (who also undertook other functions) and two police vehicles on the road (assuming all officers were available).[58]

150. When Sergeant Kendall undertook the role of shift supervisor, he was responsible for supervising the police operations in Broome and also, depending on need, Fitzroy Crossing, Derby and Karratha. Policing tasks in these areas were allocated by the Broome CAD operator. Telephone calls for emergency police assistance needed to be prioritised by the Broome CAD operator, who would also be called upon to perform physical

[57] ts 100 - 101
[58] ts 101

cell checks, whereupon the shift supervisor would take over the CAD functions.[59]

151. The Broome police station's Lock-up would also be utilised as the central lock-up for the Kimberley region. Sergeant Kendall recalled up to 17 detainees in the Lock-up on an occasion. On 29 and 30 November 2012, there were up to seven detainees in the Broome Lock-up.[60]

152. It was not uncommon for the police officers on a shift to share the task of performing cell checks, and to assist each other depending on availability. It was not uncommon for cell checks to be undertaken remotely, by CCTV camera.

153. Senior Constable Colman, who was responsible for the overnight cell checks for Ms Mandijarra during his shift, recalled that at one point he had been required to attend to a complainant at the front counter in relation to an alleged assault, and that Sergeant Kendall took over the cell check function. Senior Constable Colman considered that compliance with the Broome Manual's cell check requirements in 2012 was impractical based upon his workload requirements most nights.[61]

154. Senior Constable Colman also pointed to the difficulty he experienced in recording the times of his cell checks and his observations of the detainees at the material time:

> *"….all I can say is I was very vigilant, and definitely more vigilant in regards to both remote and physical checks than I would have been documenting them, and that's purely just because of workload at the time. It was just about impossible to keep up with everything that was going on."*[62]

155. Senior Sergeant Van Der Ende recalled that on the busy nights (Thursday to Saturday) compliance with the Broome Manual cell check requirements would have been a challenge.[63]

156. The experiences of other police officers regarding the impact of workloads and of competing tasks in 2012 were to similar effect. Mr McDonald recalled that compliance with the Broome Manual's cell check requirements could be achieved

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[59] ts 101 - 103
[60] ts 102
[61] ts 263 - 265
[62] Ts 293
[63] ts 193

with great difficulty and it required cooperation from all staff members. By way of example, whilst he was not responsible for cell checks himself, when he conveyed a detainee to a cell, he would walk along and interact with the other detainees, and pass that information onto the shift supervisor. That would be treated as a cell check.[64]

157. Constable Wright recalled that in 2012, with incoming back-to-back telephone calls and radio calls, it was easy to lose track of the 15 to 20 minute intervals for conducting the cell checks. He recalled that due to workload pressures and no dedicated Lock-up keeper, the police officers would assist each other with cell checks: *"....it was in all of our best interests to relieve the pressure off each other and have prisoners safe and healthy. So, if we were walking through the lockup, it wouldn't be uncommon to just go and check on everyone and come back, let them know, so they can put the entry in or watch you put the entry in yourself.*[65]

158. It is against this background, namely the Broome Manual's requirements and the workloads in 2012, that the cell checks undertaken for Ms Mandijarra are assessed, below.

159. The improvements to the staffing numbers and the cell check procedures are addressed later in this finding.

Ms Mandijarra's Cell Checks on 29 and 30 November 2012

160. At the inquest I received evidence concerning the cell checks that were undertaken for Ms Mandijarra on 29 and 30 November 2012.[66]

161. Ms Mandijarra was placed into Cell 4 of the Lock-up by Mr McDonald at approximately 7.15 pm on 29 November 2012 and Constable Wright entered a contemporaneous record onto the Custody system. Two other female detainees were already in Cell 4. About 10 minutes later, at approximately 7.25 pm, Mr McDonald re-entered Cell 4 for the purpose of releasing the other two female detainees. Whilst it is likely that he observed Ms Mandijarra, no record of that observation was made on the Custody system.

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[64] ts 24 - 25
[65] ts 344 - 345
[66] Exhibit 2, tabs 1, 4, 5, 6 and 7; Exhibit 5, tab 7

162. For a number or hours afterwards, Ms Mandijarra was the only occupant of Cell 4. There is no record concerning Ms Mandijarra made in the Custody system until 8.42 pm when, as part of what was known as *"batch"* recording, Senior Constable Colman made an entry denoting a remote cell check as follows: "*Detainees all lying down and all appears correct*".

163. The recorded CCTV vision from the camera in the corridor reflects that at 7.48 pm movement was visible through the viewing pane of the door to Cell 4 and that at 8.15 pm, a police officer looked inside Cell 4, through the viewing pane. No relevant observation was recorded in the Custody system.

164. Accordingly, there were no physical cell checks between approximately 7.25 pm and 8.15 pm, a period of some 50 minutes. Further, when the 8.42 pm cell check was recorded, it is apparent that was been undertaken remotely, through the CCTV camera which is inadequate.

165. It is immediately apparent that Ms Mandijarra has not had physical cell checks that have been recorded on the Custody system at 15 minute intervals for the first two hours, as was required.

166. The recorded CCTV vision from the camera in the corridor reflects that at 8.54 pm movement was visible through the viewing pane of the door to Cell 4, and that at 10.54 pm, another female detainee was placed into Cell 4 by Mr McDonald and Detective First Class Constable Marchesani. Two minutes earlier, Senior Constable Colman had looked into Cell 4 through the viewing pane.

167. There were no physical cell checks undertaken in respect of Ms Mandijarra between 8.15 pm and 10.52 pm, a period of some two and three quarter hours. By this stage, Ms Mandijarra was supposed to have had physical cell checks every 15 minutes until 9.15 pm and half hourly thereafter, with records of observations being entered on the Custody system.

168. When the female detainee was placed into Cell 4 at 10.54 pm, Mr McDonald observed that Ms Mandijarra was asleep and snoring. Detective First Class Constable Marchesani was with him and she heard Ms Mandijarra move on the mattress that she was sleeping on. Her observation was brief, but she saw

that Ms Mandijarra rolled over, to face the wall.[67] These observations were then recorded by Senior Constable Colman at 10.57 pm as a physical cell check with the entry: "*Detainees checked and all appears correct*".

169. The recorded CCTV vision from the camera in the corridor reflects that at 11.20 pm Senior Constable Colman looked into Cell 4 through the viewing pane. At 11.28 pm he made an entry into the Custody system denoting a remote cell check in the following terms: "*Detainees sleeping, all appears correct*". A few minutes later he completed the electronic records for Ms Mandijarra's grant of conditional bail, in anticipation of her release in the morning.

170. The recorded CCTV vision from the camera in the corridor reflects that at 12.22 am on 30 November 2012, one hour after Ms Mandijarra's last physical cell check, Senior Constable Colman looked into Cell 4 through the viewing pane. By this stage Ms Mandijarra was supposed to be having half hourly physical cell checks.

171. There is no subsequent record of Senior Constable Colman's 12.22 am observations in the Custody system. He is also seen to look into Cell 4 through the viewing pane on two occasions between 12.49 am and 12.50 am. These latter observations were then recorded by Senior Constable Colman at 1.01 am as a physical cell check with the entry: "*Detainees sleeping, all appears correct*".

172. Shortly afterwards at 1.15 am Senior Constable Colman made a record of a remote cell check with the entry: "*Detainees sleeping, all appears correct*". The same occurred at 1.58 am and 2.21 am on 30 November 2012.

173. The recorded CCTV vision from the camera in the corridor reflects that at 2.24 am on 30 November 2012, approximately one hour and forty minutes after Ms Mandijarra's last physical cell check, Senior Constable Colman looked into Cell 4 through the viewing pane. This is recorded by him at 2.29 am as a physical cell check with the entry: "*Detainees sleeping all appears correct*". By this stage Ms Mandijarra was supposed to be having half hourly physical cell checks.

174. Senior Constable Colman recorded two further remote cell checks at 3.17 am and 3.33 am on 30 November 2012, once

[67] ts 47 - 48

again stating on each occasion: "*Detainees sleeping, all appears correct*".

175. The recorded CCTV vision from the camera in the corridor reflects that at approximately 4.15 am on 30 November 2012 movement was visible through the viewing pane of the door to Cell 4. This was the other female detainee and not Ms Mandijarra.

176. Moments later, just after 4.15 am on 30 November 2012, Detective First Class Constable Marchesani opened the door to Cell 4 for the purposes of removing the other female detainee. At this point she looked in and observed that Ms Mandijarra had her left arm out to the middle of the cell and her body was facing the centre of the cell, in the opposite position to that which she had last observed her in when she placed the other female detainee in Cell 4 at 10.54 pm the previous night.[68]

177. Detective First Class Constable Marchesani took the other female detainee into the charge room for the purpose of her release, and Ms Mandijarra remained in Cell 4, as the only occupant. Detective First Class Constable Marchesani thought Ms Mandijarra was sleeping. She did not look for signs of life. When she opened the door to Cell 4, the other female detainee walked straight out with the result that she only observed Ms Mandijarra for a few seconds. Detective First Class Constable Marchesani was not conducting a cell check for Ms Mandijarra.[69]

MS MANDIJARRA IS FOUND UNRESPONSIVE

Resuscitation efforts

178. At 4.29 am on 30 November 2012, approximately two hours after Ms Mandijarra's last physical cell check, Senior Constable Colman went to Cell 4 to endeavour to rouse Ms Mandijarra. By this stage Ms Mandijarra was supposed to be having half hourly physical cell checks. To Constable Colman, Ms Mandijarra appeared to be sleeping and there was nothing unusual about her position. Alarmingly however, Ms Mandijarra was found to be unresponsive.

[68] ts 48
[69] ts 49

179. When he entered Cell 4, Senior Constable Colman initially tried to rouse Ms Mandijarra verbally. He did this several times, with no response from Ms Mandijarra. He touched her shoulder and she still did not respond. At this point he placed his hand on her bicep and spoke to her. Having received no response he checked for a radial pulse and a carotid pulse. He could not detect a pulse.

180. Senior Constable Colman immediately called for assistance and made arrangements for a Priority 1 ambulance to be called. He commenced to perform CPR on Ms Mandijarra. Detective First Class Constable Marchesani immediately telephoned 000 and then attended Cell 4. She could not detect a pulse either. She ran to the charge room to obtain a defibrillator, but discovered there was not one available.[70]

181. When Senior Constable Colman had touched Ms Mandijarra's bicep in his endeavours to rouse her, he noted it was warm. He also recalled her neck was warm, when he checked for a carotid pulse. However, when he had checked for a radial pulse, he noted that her wrist was cold. Detective First Class Constable Marchesani recalled that Ms Mandijarra's skin was cold.[71]

182. The St John Ambulance patient care record reflects that a call was received at 4.34 am on 30 November 2012, and that the ambulance departed within a matter of minutes, arriving at the Lock-up at 4.44 am. When the paramedics arrived they took over the CPR that was being conducted by the police officers. The paramedics observed that Ms Mandijarra was unconscious to painful stimuli and had no spontaneous respiratory effort. No pulse was detected.[72]

183. Ms Mandijarra was intubated and the paramedics continued CPR. The cardiac monitor confirmed asystole (meaning that no heart rhythm was detected). The paramedics observed her skin was cool to touch, her pupils were fixed and dilated and there were no active signs of life. They ceased CPR at 4.55 am on 30 November 2012 at which point, tragically, Ms Mandijarra was pronounced dead.[73]

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[70] ts 53
[71] Exhibit 2, tabs 10 and 17; ts 277 - 278
[72] Exhibit 3, tab 35
[73] Exhibit 1 Tab 2 and Exhibit 3 Tab 35

Ms Mandijarra's last known signs of life

184. The facts concerning Ms Mandijarra's last known signs of life are as follows:

a) at 10.54 pm on 29 November 2012, Mr McDonald and Detective First Class Constable Marchesani observed Ms Mandijarra breathing and moving, whilst apparently asleep; this is the most compelling evidence concerning her last known signs of life;

b) at 2.24 am on 30 November 2012, Senior Constable Colman looked into Cell 4 through the viewing panes for about eight seconds, and can be seen to particularly focus his attention through the pane that would have afforded a view of Ms Mandijarra for most of that time. It was a physical cell check but unfortunately he did not have a practice of recording his specific observations. I therefore do not have a contemporaneous record of what he observed. At the inquest he answered as follows:

> *"What checks did you make to ensure that Ms Mandijarra was alive essentially during the night?---Well, visible checks through the window of the cell, and remote cell checks through the CCTV cameras. I did not speak to her, and I – I can't tell you whether I actually saw her – the rise and fall of her – her breath, her snoring, breathing, anything like that. At that time I didn't record those sorts of things which was something that was drawn to my attention afterwards, and we were required to make specific – specific notes on every detainee, and their body position, and what was taking place at the time."*[74]

c) Senior Constable Colman testified that his usual practice was to look for the rise and fall of the chest through the viewing pane. It appears that in Ms Mandijarra's case, throughout the night he placed significant reliance on the fact that she was sleeping in what he described as a "*natural*" or "*perfect*" recovery position, which allayed concern. With respect to her sleeping position he said:

> "*I had seen that literally hundreds of times. People go to sleep, they're exhausted, and they are drunk, and they sleep in a comfortable position, and they will stay in that position until they – they wake.* [75]

[74] ts 274
[75] ts 268, 273 - 275 and 293

d) On the evidence before me I cannot be satisfied that at 2.24 am Senior Constable Colman adopted his usual practice of observing a specific sign of life for Ms Mandijarra, beyond his interpretation of her natural sleeping position (which is not a sign of life). It is possible that he did observe a sign of life such as the rise and fall of her chest, and it certainly cannot be discounted. The lack of a specific record of his observation of Ms Mandijarra is unhelpful; unfortunately the computer system at the time allowed for "*batch*" recording by the making a generic entry for a number of detainees,[76] and the practice was not uncommon.

e) Importantly however, in light of Ms Mandijarra's risk status, observation of a sign of life, such as a movement or the rise and fall of her chest would indicate that she was alive, but it did not address her safety and welfare. By 2.24 am on 30 November 2012, her health was likely to have been severely compromised and she was in need of hospitalisation.

f) Senior Constable Colman's last recorded remote cell check was through the CCTV camera (in respect of more than one detainee) at 3.33 am on 30 November 2012. I am not satisfied that Senior Constable Colman observed the rise and fall of Ms Mandijarra's chest, or any other specific sign of life on this occasion (in evidence he conceded that it was not possible to observe the rise and fall of a detainee's chest from the remote CCTV camera, unless the detainee was breathing deeply);[77]

g) The other female detainee who shared Cell 4 with Ms Mandijarra between 10.54 pm on 29 November 2012 and approximately 4.15 am on 30 November 2012 slept throughout most of the period. When she awoke, she thought Ms Mandijara was sleeping, though she did not observe any breathing or movement. In the circumstances, given she slept most of the night, I would not have expected such observations.

185. I am satisfied that even if Ms Mandijarra displayed a sign of life at 2.24 am on 30 November 2012, her safety, welfare and reasonable needs were not addressed on that occasion. They were not addressed at 3.33 am through the CCTV either. The police at the time were focussed on signs of life, as opposed to

[76] "*Detainees sleeping, all appears correct*"
[77] ts 268

safety and welfare needs. Senior Constable Colman's practice was not uncommon and he explained that he did not consider it appropriate to continually wake a detainee in order to ascertain welfare.

186. When Detective First Class Constable Marchesani removed the other female detainee from Cell 4 just after 4.15 am, she was focussed on that function and, quite reasonably, was not able to comment on any observation of Ms Mandijarra; she was not tasked with cell check duties.

187. When Senior Constable Colman attended to Ms Mandijarra at 4.29 am on 30 November 2012 in order to release her, he observed her to still be lying on her side in what appeared to him to be a natural sleeping position. He recalled having seen her in that position throughout the night and he had no memory of seeing her move from that position. At the material time, he was also responsible for cell checks in respect of seven other detainees.[78]

188. Given the lack of clarity concerning the presence of signs of life in Ms Mandijarra throughout the period of her detention after 10.45 pm on 29 November 2012, the inquest explored whether there was any evidence, to the requisite standard, that would reflect on the likely timing of her death.

189. The forensic pathologist Dr Gerard Cadden, having considered the information regarding Senior Constable Colman's observations of warmth in one limb, and no observation of rigidity, opined that this would support an argument to the effect that Ms Mandijarra was deceased either very recently to the time she was found, and up to a period of a few hours before she was found, but would not establish that argument. I accept Dr Cadden's evidence to the effect that post mortem interval determination is fraught with difficulties and is to be approached with extreme caution.[79]

190. On all of the evidence before me, it is possible that Ms Mandijarra was already deceased during Senior Constable Colman's remote cell check at 3.33 am, but it is not established. Ms Mandijarra's last known clear signs of life are at 10.54 pm on 29 November 2012, and she may have displayed some sign of life at 2.24 am. She most likely survived beyond 2.24 am, but it cannot be known how long after that time.

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[78] ts 273
[79] Exhibit 5, tab 14; ts 317 - 318

CAUSE AND MANNER OF DEATH

191. The forensic pathologist, Dr Gerard Cadden, made a post mortem examination on the body of Ms Mandijarra at the State Mortuary on 4 December 2012. After further and comprehensive investigations, on 10 December 2013 he provided a report of his findings. In light of some additional investigations a further written report was produced and he gave evidence at the inquest.[80]

192. The extensive investigations were undertaken in an effort to ascertain a cause of death. Dr Cadden did not find evidence of established (or deep-seated) infection at post mortem. Ultimately he was not able to ascertain a specific cause of death on all of the material before him, and he proffered his opinion on the potential explanations, including the role of sepsis. The details appear below.

Potential explanations for cause of death

193. Upon initial examination Dr Cadden found no gross pathology or injury such as would readily explain the death. At this point he found no identifiable cause of death or focus of deep-seated infection such as pneumonia. He noted that arm and leg ulcers were present. Dr Cadden ordered further investigations.

194. Dr Cadden had reviewed Ms Mandijarra's medical notes from Broome Hospital. He noted her past medical history of alcohol abuse and type II diabetes mellitus (which was recorded as being poorly controlled), her frequent presentations for skin sepsis and/or cellulitis and her multiple trauma related attendances, primarily in connection with alcohol-related assaults.

195. As part of the post mortem examination Dr Cadden sought a report from the odontologist Dr S. Knott, which became immediately available to him on 4 December 2012.[81] Dr Knott concluded there were no signs of trauma to the tissue outside or inside the mouth. Dr Cadden did not see an injury

[80] Exhibit 1 Tab 5; Exhibit 5, tab 14; ts 312 - 323
[81] Exhibit 5 Tab 11

anywhere else on the face and he did not see significant injury anywhere else on the body.[82]

196. Toxicological analysis was ordered and became available to Dr Cadden by way of final report in January 2013. It was disclosed that a level of alcohol was detected in the blood at 0.073% and in the urine at 0.120%. Cannabis products were identified. Amphetamines, benzodiazepines and morphine were reported as negative in immunoassay of the blood.[83]

197. On 12 December 2012 specialist neuropathologist Dr V. Fabian undertook a macroscopic examination of the brain and found no significant abnormalities. On 20 December 2013 following a detailed microscopic examination of the brain again Dr Fabian found no significant abnormalities.[84]

198. On 10 December 2013 Dr Cadden provided his opinion on the cause of Ms Mandijarra's death, but noted that he awaited finalisation of neuropathology of the brain to ascertain if there were some findings that would support a vulnerability to seizures. As it transpired, by report shortly thereafter, none were found.

199. When Dr Cadden provided his opinion on 10 December 2013, given the limited avenues with regards to cause of death, which was unascertained, he recommended to the coroner that a report be sought from a clinical microbiologist on the issue of the role of sepsis in the case. This report was duly sought from Dr Speers on 5 February 2014 and made available to Dr Cadden on 28 April 2014.[85]

Dr Speers' evidence

200. Dr Speers has been a practising infectious diseases physician and clinical microbiologist for approximately 18 years. He is Department Head of the PathWest Microbiology laboratories for the QE II Network and Chair of the Microbiology Discipline. He is the Infection Control Officer and a member of several expert advisory groups for the state and nationally. He is highly qualified in his area.

[82] ts 319
[83] Exhibit 1 Tabs 5 and 7
[84] Exhibit 1 Tab 6
[85] Exhibit 1, tabs 5 and 8

201. Dr Speers reviewed the post mortem microbiology analyses of tissue samples that had been removed from Ms Mandijarra's body in order to investigate her death. He provided a written report and gave evidence at the inquest.

202. Dr Speers noted that post mortem microbiology found an abundant growth of *Streptococcus dysgalactiae* (a haemolytic streptococcus) from samples of the right and left lung and the spleen, and in the blood and urine. *Streptococcus agalactiae* (another haemolytic streptococcus) was found in the urine. *Staphylococcus aureus* was found in the blood. *Streptococcus pyogenes* and *Staphylococcus aureus* were also found in a number of swabs, including on the right shin ulcer swab and the right forearm ulcer swab. No viruses or other pathogens were found.[86]

203. In Dr Speers' experience, persons with poorly controlled diabetes mellitus are prone to skin infections with *Staphylococcus aureus* and haemolytic streptococci, especially in the Kimberley region. He noted that Ms Mandijarra was documented to have had frequent skin infections with these organisms before death, some of which required either washout or repeat courses of antibiotics.[87]

204. *Staphylococcus aureus* is a commensal organism (meaning that it frequently lives on people's skin without causing harm). Colonisation can occur when the host defences are breached (for example, a wound).[88]

205. Complications from poorly controlled diabetes mellitus can include the reduction of blood supply to the limbs, and impairment of the immune system. Chronic excess alcohol intake can compound that impairment. The presence of extra glucose in the blood can encourage the growth of bacteria. Dr Speers did not have a blood glucose level in respect of Ms Mandijarra.[89] However, I am satisfied that her diabetes mellitus was poorly controlled at the time of her death.

206. In his report Dr Speers opined that it was reasonable that the *Streptococcus dysgalactiae* and/or *Staphylococcus aureus* was a cause of septicaemia at the time of Ms Mandijarra's death, noting that skin sepsis was present. However in the absence of established infection being found at post mortem

[86] Exhibit 1 Tab 8
[87] Exhibit 1, tab 8
[88] Exhibit 4, tab 51
[89] ts 305-306

examination and on the basis of information available to him, he could not conclude that serious sepsis was present at the time of her death.[90]

207. Ms Mandijarra had an established history of infective complications due to these organisms, and they were readily isolated from multiple sites at post mortem examination.[91] However, this was not sufficient to establish the nexus to serious sepsis at the time of her death.

208. Given the complexities involved in ascertaining a cause of death, and evaluating the impact of the microbiology results, I heard evidence on the likely causes of death at the inquest.

209. One of the complications of significant skin sepsis can be the spread of bacteria to the blood stream and thereby to other organs, such as to cause secondary infections (for example bone infections or osteomyelitis, joint infections or septic arthritis, pneumonia, and/or infections in muscle or the spine).

210. Dr Speers was questioned about the implications of the *Streptococcus dysgalactiae* being recorded as abundant in growth in the microbiology findings. He opined that this usually indicates that there was an infection involving those particular sites. The information before him reflected that there was an abundant growth from multiple sites, but without other bacteria being found.

211. There was evidence of infection in the bloodstream reflected by the isolation of bacteria from the blood itself. Dr Speers believed it would most likely represent bacteraemia (bacteria circulating in the bloodstream) at the time that the specimen was collected.[92]

212. Dr Speers commented on the symptoms that Ms Mandijarra may have exhibited as a result of those infections. He opined that in relation to a wound that becomes infected, it would usually develop redness which would be visible, and would cause an increase in pain. The person may also develop fluid accumulation and/or discharge from the infection process.[93]

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[90] Exhibit 1, tab 8
[91] Exhibit 1 Tab 8
[92] ts 303-304
[93] ts 303-304

213. If the infection were to spread into the bloodstream, Dr Speers opined that there would be the development of more systemic features. The person would develop a fever and feel unwell. There would be a loss of appetite and possibly even vomiting. There would often be complaint of generalised aches and pains.

214. If the wound appears as an abscess that requires drainage it is more likely to be a *Staphylococcus aureus* infection. If the wound has an inflamed and red appearance it is more likely to be a *Streptococcus dysgalactiae* infection. Both are known causes of skin sepsis.

215. If the infection in the bloodstream progresses unchecked the person could develop septic shock. The person may become confused or sleepy, there would be signs of loss of production of urine, and blood pressure would drop. As such an infection continues its progression, the person would become less able to function, and is more likely to lie down or take to bed.

216. Depending on the individual person, if infection is diagnosed and antibiotics are administered, the infection may be successfully treated. If infection is left untreated, outcomes will vary and in a small number of people, both the haemolytic streptococci and the *Staphylococcus aureus* can cause serious sepsis followed by significant organ damage, leading to death.[94]

217. One possible explanation for the microbiology results was that sepsis may have been present but not established as a deep-seated infection such as to contribute to Ms Mandijarra's death by an arrhythmia, or to have triggered a seizure. Ms Mandijarra was at risk of ischaemic heart disease due to diabetes, and medical records reflected that Ms Mandijarra had suffered a seizure secondary to pneumococcal sepsis in 2010.[95]

218. Dr Speers was aware of Ms Mandijarra's medical history of elevated C-reactive protein. This suggested to Dr Speers that Ms Mandijarra was more prone to have seizures or cardiac arrhythmias, which can subsequently contribute to death.

219. Ms Mandijarra's behaviour in the charge room on the night of 29 November 2012 was uncharacteristically erratic and may

[94] ts 306-307
[95] Exhibit 1 Tab 8

not have been attributable solely to her intoxication. She did display signs of confusion, and it is possible that she was already quite unwell when she began to remove her clothes.

220. In Dr Speers' experience, confusion and a global deterioration in function (including somnolence) is a recognised symptom of serious infection or sepsis and there would not necessarily be focal neurological signs to support this.[96]

221. Professor Thompson considered that Ms Mandijarra's erratic behaviour at the police station, and posited that it may have been related to some sort of deliria associated with and masked by her alcohol intoxication.[97]

222. At the inquest Dr Speers was questioned on how long bacterial infection would take to cause death. In Dr Speers' experience, it could range from days to weeks. A person would not normally succumb to *Staphylococcus aureus* infection within a number of hours.

223. Based upon the material before him, Dr Speers was not able to conclude that Ms Mandijarra died as a result of an infection. The fact remained that whilst the microbiological analysis isolated bacteria in abundance from multiple sites, the post mortem examination reflected that there was a lack of deep-seated infection.[98]

224. Signs of deep-seated infection at post mortem would have included abscesses or pneumonia, or deep-seated bone and/or joint infection. Such signs would demonstrate that infection was a significant and direct cause of death. However, none were found by the forensic pathologist.

225. Dr Speers' analysis supported a finding to the effect that while the cause of Ms Mandijarra's death could not be ascertained, the role of sepsis could not be excluded.

Dr Cadden's evidence

226. The forensic pathologist Dr Cadden gave evidence at the inquest. This was in the context of his post mortem findings,

[96] ts 305
[97] ts 162
[98] ts 307

Dr Speers' initial report to him[99] and after hearing Dr Speers' evidence at the inquest.

227. Dr Cadden, having considered Dr Speers' written report dated 28 April 2014, provided a further report to the coroner dated 22 February 2016 following a request to him for further review on 18 February 2016.[100] In his further report, Dr Cadden concluded that on balance Dr Speers considered sepsis/septicaemia as a potential explanation for Ms Mandijarra's death. I accept Dr Cadden's interpretation of Dr Speers' report, and Dr Speers' evidence at the inquest was entirely consistent with it.

228. Dr Cadden opined that other possibilities as to Ms Mandijarra's cause of death were:

a) A seizure due to underlying sepsis (similar as to what occurred in 2010);

b) A seizure due to alcohol withdrawal;

c) Cardiac arrhythmia due to acute ethanol cardiotoxicity or focal coronary atherosclerosis (which was more evident microscopically than focally); or

d) Airway obstruction whilst intoxicated, leading to the cessation of breathing.[101]

229. In Dr Cadden's experience, diabetes mellitus makes a person more susceptible to sepsis/septicaemia. He also explained that Ms Mandijarra's blood alcohol levels would have been anticipated to have been much higher than the levels found at death, and certainly so at the earlier part of her detention.

230. At the inquest Dr Cadden testified as to the possible explanations for Ms Mandijarra's death that are outlined above. The most likely of the possibilities was a seizure due to underlying sepsis, given what is known of Ms Mandijarra's vulnerability to seizures. Another possible trigger for a seizure was her intoxication.[102]

[99] Exhibit 1 Tab 8
[100] Exhibit 5 Tab 14
[101] Exhibit 5 tab 14
[102] ts 317-318

231. Seizures may vary in their manifestation, from not being floridly obvious to being floridly obvious. An unwitnessed seizure may result in death, by compromising the airway.[103]

232. Having considered Dr Speers' written report and evidence at the inquest, Dr Cadden remained of the opinion that the cause of Ms Mandijarra's death was unascertained. Like Dr Speers, he took account of the microbiology report results, but the lack of deep-seated infection in the body organs persuaded him that he could not opine that septicaemia was the cause of death.[104]

233. In Dr Cadden's experience where septicaemia is a cause of death there is usually some focus of major organ infection and usually in the lungs. On examination, Dr Cadden did not find pneumonia in the lungs. Nor did he find endocarditis, or a brain abscess.

234. Whilst Dr Cadden thought that Ms Mandijarra had sepsis on the basis of the bacteria that had been isolated, and whilst he favoured a septic explanation, he was not able to say that the consequence of that septicaemia was her death. His opinion remained as expressed in his post mortem report.[105] His evidence on the issue was consistent with that of Dr Speers.

Cause of death

235. After comprehensive investigations Dr Cadden remained of the opinion that he expressed on 10 December 2013, namely that Ms Mandijarra's cause of death was unascertained (consistent with *Streptococcus dysgalactiae* and *Staphylococcus aureus* septicaemia in a woman with diabetes mellitus).

236. On the evidence before me it is not possible to establish the nexus between the microbiology results and her death to the requisite standard. However, the microbiology results cannot be dismissed.

237. I accept and adopt Dr Cadden's opinion on the cause of death.

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[103] ts 322
[104] ts 313-314
[105] ts 319 - 320

Manner of death

238. There is no evidence before me to suggest that Ms Mandijarra died from any cause of death other than a natural cause. I therefore find that the manner of Ms Mandijarra's death was by way of natural causes.

WAS MS MANDIJARRA'S DEATH PREVENTABLE?

239. Given that Ms Mandijarra's cause of death remains unclear it is not possible to positively find how her death may have been prevented. However Ms Mandijarra's death was potentially preventable, particularly if she had been taken to hospital on the night of 29 November 2012, and if she had been monitored there. If she had suffered a seizure or developed signs of sepsis at the hospital, she may have successfully been treated.

240. At the time of Ms Mandijarra's arrest she was intoxicated, and uncharacteristically aggressive and uncooperative. She refused to answer the usual admission questions and did not voluntarily divulge any symptoms if indeed she had any, or was aware of any. She did not complain of pain and there was nothing to indicate that she was febrile.

241. The police are not medically trained personnel. They did not discern that Ms Mandijarra was ill. They were aware that she was highly intoxicated but they did not consider that she was in need of medical attention as a result of that, or for any other reason.

242. At the inquest Senior Constable Colman explained the procedure regarding arrangements for medical assessments for intoxicated detainees at the material time. He confirmed that if the detainee was able to talk, walk without stumbling over, hold their own weight, remain in control of their faculties, the procedure was to not take the detainee to hospital for medical assessment.[106]

243. The police would assess detainees' needs for medical assessment on a case by case basis. At the material time Senior Constable Colman was aware that many of the detainees were heavily intoxicated, and in his view Broome

[106] ts 282

police did not have the physical capacity to take each such person to hospital.[107]

244. Detective Sergeant Kendall's evidence was that at the material time a detainee would be conveyed to hospital if they displayed signs of physical or mental health illness that could not otherwise be attributed to intoxication. Examples included injuries from assault or a psychotic episode. Like Senior Constable Colman he was of the view that some discretion needed to be exercised before taking a detainee to hospital on the basis of intoxication alone.[108]

245. Unfortunately, whilst the police IMS system contained previous electronic records of the risk of Ms Mandijarra suffering "*epileptic fits*" and of having a medical condition that required prescribed drugs, the police responsible for her welfare that night either did not see them, or did not focus on them.[109]

246. At the inquest First Class Constable Wright, who admitted Ms Mandijarra into custody, did not recall accessing this information. He assessed her level of risk based upon her behaviour on the evening of 29 November 2012. In his earlier interview, he confirmed he was unaware that Ms Mandijarra suffered from diabetes or epilepsy.[110]

247. Professor Sandra Thompson prepared a report and gave evidence at the inquest.[111] She is a professor of rural health at the University of Western Australia and director of the Western Australian Centre for Rural Health. Her qualifications are in the areas of medicine, science and public health. Professor Thompson addressed Ms Mandijarra's susceptibility to illness by reference to the social determinants of ill health.

248. In Professor Thompson's experience, Aboriginal people in general experience a much higher likelihood of social disadvantage that impacts profoundly upon their health. The constellation of lower year 10 and 12 completion rates, lower post-secondary education participation and attainment, lower labour force participation, lower household and individual income, lower home ownership and higher rates of homelessness distinguishes Aboriginal disadvantage and

[107] ts 282
[108] ts 95 and 106
[109] Exhibit 2, tab 1; Exhibit 5, tab 5
[110] Exhibit 2, tab 9; ts 338 - 339
[111] Exhibit 4, tab 51; ts 154 - 176

underpins their diminished wellbeing and lower life expectancy.[112]

249. Professor Thompson outlined the DSM-IV criteria for diagnosis of substance abuse and Ms Mandijarra clearly met that criteria. Aboriginal people are more likely than non-Aboriginal people to experience life stressors that can be overwhelming. Self-medicating with alcohol to cope with stressors is not uncommon, but it is ultimately both futile and destructive. The causes of substance abuse are varied, but the outcomes are sadly predictable.

250. Professor Thompson identified alcohol misuse as a contributing factor to a wide range of health and social problems, including violence, social disorder, family breakdown, child neglect, loss of income or diversion of income to purchase alcohol and other substances, and high levels of imprisonment.[113]

251. Professor Thompson considered the prevalence of harmful alcohol use in the Aboriginal population and its relationship to a reduced life expectancy, informing the court as follows:

> *"It is likely that the prevalence of harmful alcohol use in the Indigenous population is about twice as great as that in the non-Indigenous population, based on surveys and data on the prevalence of health problems known to be caused by alcohol. In addition, Indigenous Australians experience harms associated with alcohol use, including deaths and hospitalisations, at a rate much higher than other Australians."*[114]

252. Professor Thompson identified various reasons for rates of diabetes mellitus being much higher in Aboriginal people than non-Aboriginal people. The risk increases for persons born into lower socio-economic environments, and traverses factors as varied as poor intrauterine growth and weight gain. At the inquest she explained that Indigenous Australians are affected by diabetes at approximately three times the rate of the non-Indigenous population, and that this statistic does not even take account of the lower age profile of affected Indigenous Australians.[115]

253. Alcohol abuse adds an additional glucose load that makes it harder to control diabetes. Consistent with the evidence of

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[112] Exhibit 4, tab 51
[113] Exhibit 4, tab 51
[114] Exhibit 4, tab 51
[115] ts 155 - 156

Dr Speers and Dr Cadden, Professor Thompson explained that infectious diseases are more frequent and/or serious in patients with diabetes. This is caused by the hyperglycaemic environment that results in poorer immune function (such as impaired neutrophil function, depression of the antioxidant system and reduced humoral immunity) as well as impaired circulation to tissues (micro- and macro-angiopathies).[116]

254. *Staphylococcus aureus* infections are more common among Aboriginal people than other Australians. Whilst more common also in males than females, the fatality of staphylococcal bacteraemia is estimated to be twice as high in females as in males.[117]

255. *Streptococcus dysgalactiae* is a bacterium that is not unusual as a coloniser of the human upper respiratory tract and is often present in skin lesions. The effects can range from harmless superficial skin infections to life-threatening toxic shock-like syndromes.

256. Control guidelines for management of skin infections emphasise the importance of personal and household hygiene, including covering wounds, hands regularly washed with soap and water, regular bathing, clothing laundered after each use. These were all measures that were plainly unavailable on a consistent basis to Ms Mandijarra when she was homeless.

257. In Professor Thompson's opinion, when persons are as intoxicated as Ms Mandijarra was, it would be more appropriate that they be cared for in a hospital setting as opposed to remaining in detention in a lock-up setting. She explained that if police had taken Ms Mandijarra to hospital on 29 November 2012, she would likely have been regularly monitored, having her blood pressure taken, and she would probably have been rehydrated intravenously.[118]

258. Like the police, she noted that the public health system is not necessarily sufficiently funded to deal with all alcohol-affected patients. However, she made a distinction in the case of Ms Mandijarra, having regard to her individual circumstances, including her high level of intoxication. [119]

[116] Exhibit 4, tab 51
[117] Exhibit 4, tab 51
[118] ts 163
[119] ts 165 - 166

259. Professor Thompson noted that Ms Mandijarra had refused attendance at the local Aboriginal health service and that she did not appear to attend any other primary care centre. I accept Professor Thompson's opinion to the effect that Ms Mandijarra's needs would have been best managed in a primary health care setting where a holistic approach to her health may have been possible.[120] It is unfortunate that this was not able to occur, and it is not clear why Ms Mandijarra refused to attend.

260. As it transpired Ms Mandijarra's medical care was largely provided in an ED setting, which was not suited to addressing the underlying complex circumstances of her poor health. Her pattern of early morning attendances would suggest that she presented when the effects of alcohol had worn off.[121]

261. Records disclose that Ms Mandijarra was frequently non-compliant with treatment and on multiple occasions she did not wait to be seen at ED, or she discharged herself against medical advice. It is likely, as Professor Thompson posits, that Ms Mandijarra's inability to control her drinking diminished her ability to follow medical advice (which would most certainly have included the need for her to stop drinking).[122]

262. In Professor Thompson's opinion the repeated cycle of admissions to ED, incarceration and attendance at the Broome Sobering-up Shelter was unlikely to substantially improve Ms Mandijarra's health. The complexities surrounding the severe deterioration in her health would have been better addressed on an ongoing basis by supporting her in the community.[123] It would have required a co-ordinated approach between a range of entities to address her physical and mental health, her alcohol abuse, her physical safety and the availability of housing for her. It would also have required Ms Mandijarra to engage with these services. On the evidence before me, Ms Mandijarra displayed some reluctance in engaging with the entities that may have assisted her.

263. Professor Thompson noted the difficulty of monitoring an intoxicated person in a custodial setting and the risks posed by the belief that the detainee will "*sleep it off*" in the Lock-up cell. It is likely that Ms Mandijarra's level of intoxication

[120] Exhibit 4, tab 51; ts 165-166
[121] ts 158
[122] Exhibit 4, tab 51
[123] ts 161

masked factors such as her diabetes, her previous epilepsy and any sign of sepsis (which may have been underpinned by her diabetes).[124] This increased the risk of leaving her in custody overnight.

264. The ALS draw my attention to the evidence concerning the institutional factors that led to Ms Mandijarra's death in a custodial environment. Given Ms Mandijarra's history of absconding from hospital and her condition at the time of her death, ALS also submit that it seems unlikely that, if not arrested, she would have sought urgent medical assistance on 29 November 2012. The evidence before me supports this as the most likely outcome.

265. Professor Thompson's evidence was that Ms Mandijarra: "*….was having a lot of acute-related interventions rather than a kind of multi-party inter-sectoral response to the problems that she has."*[125] Neither the health system nor the police service would have been able, in their separate capacities, to effectively address Ms Mandijarra's poor state of health and recurrent alcohol abuse.

266. By the time of Ms Mandijarra's tragic death, the catastrophic cycle of her deterioration was close to intractable. Her alcohol abuse exacerbated her diabetes, which in turn aggravated her infections, from pathogens she was more likely to be exposed to due to her homelessness. The homelessness exposed her to risks of assault and a range of other dangers, and impaired her capacity to self-care and her capacity to control her alcohol abuse. Her unwillingness to interact with services that may have assisted her, and her lack of compliance with medical treatment compounded all of these overwhelmingly harmful factors.

267. Once Ms Mandijarra came under the custody of the police, their obligations to her crystallised and every reasonable opportunity ought to have been taken to safeguard her welfare. I am satisfied that whilst it was reasonable at the time for police not to take every alcohol-affected person to hospital, given the extent of Ms Mandijarra's manifest intoxication and dysfunction, and her history of alerts on the IMS and Custody systems, police ought to have taken her to hospital on 29 November 2012.

[124] ts 162
[125] ts 161

268. As the cause of Ms Mandijarra's death is unascertained, and the forensic pathologist flagged that there was a possibility of septicaemia,[126] I am satisfied that the evidence establishes that Ms Mandijarra's death could potentially have been prevented by admission to hospital on 29 November 2012. Any comment as to the likely outcome would be speculation, in light of the uncertainty surrounding the cause of her death.

ALTERNATIVES TO INCARCERATION

269. At the inquest I explored the desirability of alternatives to incarceration in similar circumstances, particularly in light of the serious health risks faced by a person such as Ms Mandijarra, given her chronic excess alcohol intake and her poorly controlled diabetes.

270. This aspect of the inquiry commences with an analysis of the legal framework for Ms Mandijarra's arrest and detention in the Lock-Up:

Legal framework for Ms Mandijarra's incarceration in 2012

271. Ms Mandijarra was apprehended by police for street drinking. Specifically it was in connection with the simple offence of consuming alcohol on unlicensed premises without the requisite consent, contrary to s 119(1) of the *Liquor Control Act* 1988 (Liquor Control Act) which provides as follows:

> *A person who consumes liquor in any place or on any premises, including any park or reserve, without the consent of the occupier, or of the person or authority having control, of that place or those premises commits an offence.*
>
> *Penalty: a fine of $2,000*

272. As a preventative measure, and with a view to deterring people from becoming intoxicated and reoffending, it was Broome police's practice to patrol areas including Male Oval frequently, relying on the provisions of s 119 of the Liquor Control Act to curb street drinking.[127]

273. A contravention of s 119 of the Liquor Control Act would not normally result in an arrest. It is not termed a "*serious offence*." However the police officer decided to arrest

[126] ts 313
[127] Exhibit 3 Tab 25

Ms Mandijarra by reason of the powers contained in s 128 of the *Criminal Investigation Act* 2006 (the Criminal Investigation Act) because he suspected that she would continue or repeat the offence. Section 128(3) provides as follows:

> *A police officer or a public officer may arrest a person for an offence that is not a serious offence if the officer reasonably suspects —*
>
> *(a) that the person has committed, is committing, or is just about to commit, the offence; and*
>
> *(b) that if the person is not arrested —*
>
> *…*
>
> *(ii) the person will continue or repeat the offence; or*
>
> *…*

274. Mr McDonald, then a First Class Constable, was the arresting officer. He formed the view that if he did not arrest Ms Mandijarra, she would likely continue the offence of street drinking. He formed this view on the basis of prior multiple dealings with her in the context of street drinking. In his experience, move on notices and liquor infringements were ineffective in curbing street drinking in Ms Mandijarra's circumstances.[128]

275. Mr McDonald also thought that if he did not arrest Ms Mandijarra, she might get into a fight with the woman with whom she had been yelling when his attention was drawn to her. He was aware the Broome police were to be pro-active regarding alcohol related offences as a result of the antisocial and alcohol fuelled behaviour at that time in Broome. In his experience, Male Oval was particularly problematic in this regard.[129]

276. At the inquest the question was raised as to whether Ms Mandijarra had in fact been apprehended and detained under the provisions of the *Protective Custody Act* 2000 (Protective Custody Act), as opposed to being arrested under s 128 of the Criminal Investigation Act. The question was explored by the Internal Affairs Unit when their review was undertaken and at the inquest Inspector Smith drew attention

[128] Exhibit 2, tab 8
[129] Exhibit 2, tab 8; ts 11 - 17

to the similar considerations in respect to the detention of an intoxicated person.[130]

277. Mr McDonald testified that he arrested Ms Mandijarra to prevent the repetition of the street drinking offence, utilising the power under s 128(3) of the Criminal Investigation Act, and that he did not apprehend her under the Protective Custody Act.[131]

278. Section 6 of the Protective Custody Act provides as follows:

> *(1) If an authorised officer reasonably suspects that a person who is in a public place or who is trespassing on private property —*
>
> *(a) is intoxicated; and*
>
> *(b) needs to be apprehended —*
>
> *(i) to protect the health or safety of the person or any other person; or*
>
> *(ii) to prevent the person causing serious damage to property,*
>
> *the officer may apprehend the person.*

279. Section 7 of the Protective Custody Act contains provisions governing the reasons for continuing the detention and limiting the amount of time that an apprehended person may be detained.

280. At the inquest, Detective Sergeant Kendall recalled at one stage believing that Ms Mandijarra had been apprehended under the Protective Custody Act (as opposed to being arrested).[132] However, at the Lock-up, it was Sergeant Kendall who made the decision not to immediately grant bail to Ms Mandijarra, and to thereby detain her. He took account of the risk of Ms Mandijarra continuing the offence for which she was arrested, and the danger to her safety or another person's safety if she were to be released in her intoxicated state.[133] These factors are consistent with the considerations outlined in s 6A(4) of the *Bail Act* 1982, and reflect Ms Mandijarra's status as an arrested person.

281. Senior Constable Colman had initially also believed Ms Mandijarra was detained under the Protective Custody Act, until he was tasked with preparing her release to bail at

[130] Exhibit 2, tab 1; ts 134
[131] ts 19
[132] ts 95 – 96; ts 261 - 262
[133] Exhibit 1, tab 9; ts 41

approximately 11.30 pm on 29 November 2012. At this stage it became clear to him that she had been arrested.[134]

282. The police officers responsible for Ms Mandijarra's welfare believed she would have been unlikely to understand her bail conditions given her level of intoxication. Senior Constable Colman prepared the release to bail with the aim that the paperwork would be ready on the morning of 30 November 2012.[135]

283. Consistent with the provisions of the *Criminal Investigation Act* 2004 and paragraph 5.8.7 of the Broome Manual Ms Mandijarra was not questioned or formally charged while she was intoxicated.

284. The Broome Police officers' practice was to consider the timing of release. The WAPOL Manual LP-09.03 provided for the deferred release of detainees between midnight and 7.30 am:

> *The officer in charge shall release the detainee within 8 hours after the initial apprehension, except:*
>
> - *"…. …..*
> - *If release of the detainee between the hours of midnight and 7.30am is not in the best interest of the detainee."*

Paragraph 5.8.5 of the Broome Manual was to similar effect.

285. The evidence reflects that the plan had been to release Ms Mandijarra at approximately 4.30 am on 30 November 2012, some nine hours after the commencement of her detention.

286. Whilst there was some confusion as to whether similar factors under the Protective Custody Act were taken into account, it is clear that Ms Mandijarra remained under arrest throughout the period of her detention at the Lock-up.

287. I am satisfied that Mr McDonald arrested Ms Mandijarra under the provisions of the Liquor Control Act read together with the Criminal Investigation Act, and that he did not detain her under the Protective Custody Act. The entries in Ms Mandijarra's Custody system records are consistent and

[134] ts 261 - 262
[135] Exhibit 1, tab 9; ts 45

reflect that she was arrested in connection with consuming liquor on Male Oval.[136]

288. I am satisfied that the arrest of Ms Mandijarra, albeit for the simple offence of street drinking, was lawful in that the arresting officer turned his mind to the basis for reasonably suspecting that she would continue or repeat the offence.

289. I am satisfied that the detention of Ms Mandijarra at the Lock-up was lawful, in that there were reasonable grounds to suspect that if she were released her safety would be endangered, and further that in her heavily intoxicated state she would be unable to properly understand the conditions of her bail.

290. I am satisfied that the planned deferral of Ms Mandijarra's release until approximately 4.30 am on the morning of 30 November 2012 was lawful.

291. However, this does not derogate from the fact that the preferred and appropriate course would have been to take Ms Mandijarra to the hospital for medical assessment, instead of conveying her to Cell 4 on the evening of 29 November 2012 and detaining her in the Lock-up overnight and I address this in further detail in my comments on supervision, treatment and care.

Options other than incarceration in 2012

292. At the inquest the police officers involved in the arrest and detention of Ms Mandijarra were questioned on the options available to them other than arresting and detaining Ms Mandijarra at the Lock-up on the evening of 29 November 2012.

293. The arresting officer Mr McDonald outlined the options other than arrest that were available to him at the material time. Clearly one option was to do nothing, he had that discretion. Other options included speaking with Ms Mandijarra, issuing a move on notice, issuing another liquor infringement or taking Ms Mandijarra to the Broome Sobering-up Shelter

[136] Exhibit 5, tabs 7 and 8; ts 11 - 16

(though he would have discovered that she was banned from the Shelter until 5 December had he elected to do that).[137]

294. Another option available to Mr McDonald was to have contacted the Kullari Patrol, which is a mini bus that transported people home from Male Oval. He did not endeavour to contact them on the night in question given Ms Mandijarra's circumstances.

295. Mr McDonald believed that as a police officer he had a duty to act. He decided not to issue a move on notice because in his experience intoxicated persons generally breached them, leading to an arrest. He decided not to issue a liquor infringement because Ms Mandijarra had previously had several of those issued against her. Whilst he was unaware that she had been banned from the Broome Sobering-up Shelter at that time, he made no attempt to contact the Shelter on the night because he observed her to be aggressive and she could not have been compelled to stay there.

296. In First Class Constable Wright's experience, options available to police that night would have included the issue of a further infringement notice, a summons, a move on notice, a verbal warning, and the tipping out of alcohol.[138]

297. Sergeant Kendall's evidence was that the other options available on the night of 29 November 2012 were less desirable than arrest. It is to be borne in mind that Ms Mandijarra was homeless. There may have been a possibility of taking her to a location at Kennedy Hill, but Sergeant Kendall was aware of her history and he believed that in her heavily intoxicated and argumentative state she was unable to look after herself and she was at risk of becoming involved in domestic violence incidents.[139]

298. Sergeant Kendall discounted the option of taking Ms Mandijarra to hospital due to sheer number of intoxicated persons that police dealt with at the Lock-up and the impracticality of taking each such detainee to hospital. Ultimately he formed the view that the best option was to detain Ms Mandijarra in the Lock-up until she was in a fit and proper state for release, and no longer a danger to herself or others.[140]

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[137] ts 15 - 19
[138] ts 332 - 333
[139] ts 95
[140] ts 95

COMMENTS ON SUPERVISION, TREATMENT AND CARE

299. My comments on the quality of Ms Mandijarra's supervision, treatment and care are made pursuant to s 25(3) of the Coroners Act, because immediately before death she was a person held in care.

300. Ms Mandijarra remained in Cell 4 of the Lock-up overnight, and Senior Constable Colman, who was responsible for the cell checks for most of her detention, believed she was sleeping. The police officers' evidence at the inquest was to the effect that it becomes oppressive to awaken a detainee at regular intervals overnight in order to ascertain welfare. This however presupposes that the detainee is simply asleep, and in a reasonably satisfactory state of health.

301. The prevailing attitude of the Broome police was to focus on observing the rise and fall of the chest during an overnight cell check. This, coupled with the posture in which the detainee appeared to be sleeping, would serve to indicate to the police officer that the detainee had displayed a satisfactory sign of life. However, it is readily apparent that in the case of a detainee who is in a fragile state of health, looking for a sign of life is inadequate.

302. Ms Mandijarra's cell checks ought to have been conducted in a manner that was apposite to her individual safety, welfare and reasonable needs. In her case, looking at her sleeping posture and/or checking for breathing was insufficient for the purpose of seeking to ensure her safety and welfare.

303. There are two main issues in the assessment of Ms Mandijarra's supervision, treatment and care:

a) the level of compliance with cell check procedures; and

b) whether she ought to have been taken to hospital instead of being detained in the Lock-up.

304. Unfortunately at the material time Sergeant Kendall and Senior Constable Colman did not ensure that they were properly and completely aware of the requirements of the Broome Manual and they did not comply with the Broome Manual's cell check requirements.

305. After Ms Mandijarra's death the Internal Affairs Unit (IAU) conducted an investigation into the matter. As a result on 12 September 2014 both Sergeant Kendall and Senior Constable Colman received managerial notices from the Detective Superintendent IAU, on the basis that during Ms Mandijarra's confinement they were charged with ultimate responsibility to supervise Ms Mandijarra and provide her with a duty of care whilst she was incarcerated. Part of that responsibility entailed regular cell checks to ensure her wellbeing, in accordance with the both the WAPOL Manual and the Broome Manual. The IAU investigation found that although they provided a level of care, the level of care did not meet the expectations as governed by section 5.3.2 of the Broome Manual.[141]

306. In the case of Sergeant Kendall, the IAU investigation found that he failed to conduct 15-minute physical cell checks as required. In the case of Senior Constable Colman, the IAU investigation found that he failed to conduct half hourly physical cell checks as required. Both police officers were found to have deviated from expected standards of good conduct and behaviour demanded by members of the Western Australia police, and both notices cited a lack of professionalism that was not within the standards of good conduct and discipline.

307. The evidence at the inquest reflected that these failures were occasioned by a lack of understanding of cell check procedures, and the impact of both workloads and individual work practices. I am satisfied that as a result of these failures, there were missed opportunities to address Ms Mandijarra's safety and welfare by cell checks throughout the night. However, I am not satisfied that cell checks alone, even if they were conducted at the requisite intervals, would have been likely to ensure Ms Mandijarra's safety and welfare.

308. Having regard to the evidence of the forensic pathologist and the observations of police, including when Ms Mandijarra was found unresponsive, it is likely that any outwardly observable manifestation of Ms Mandijarra's impending cardiac arrest was momentary and might only have occurred immediately before death.

309. The police are not medically trained personnel. Realistically only monitoring in a hospital setting would be likely to have

[141] Exhibit 2 Tab 2

detected the severity of Ms Mandijarra's deterioration. She would have needed urgent medical intervention to endeavour to treat her catastrophic collapse.

310. I am satisfied that the preferred and appropriate course would have been for police to take Ms Mandijarra to hospital on 29 November 2012 for medical assessment. Unfortunately this was not part of the procedure at the material time. The commonly held belief by the relevant Broome police officers was that it was not practicable to convey intoxicated detainees to hospital unless there was an indication of ill health requiring medical attention, over and above the intoxication. As none was observed by police in respect of Ms Mandijarra, she was conveyed to Cell 4.

311. Through their counsel, the Commissioner of Police, Sergeant Kendall, Senior Constable Colman and Senior Sergeant Van Der Ende draw my attention to the evidence concerning the heightened awareness of issues that can occur in a lock-up and of the greater emphasis on medical fitness. Their submission is that in a case such as Ms Mandijarra's police officers would now not hesitate to take a detainee to hospital or to call for an ambulance.

312. I am satisfied that Ms Mandijarra's supervision, treatment and care at the Lock-up on 29 and 30 November 2012 was deficient and fell below the standards that should ordinarily be expected of members of the Western Australia Police Service.

313. I take account of the uncertainties surrounding the cause of death. In the circumstances, it is not possible to identify the factors that may have contributed to her death. Any analysis of the symptoms that might have been displayed would be based upon speculation. I am therefore also satisfied that there is no evidence before me that suggests that Ms Mandijarra's death appears to have been caused, or contributed to, by any action of the police.

314. I accept the ALS submission that Ms Mandijarra should not have spent her last hours in a cell at the Lock-up. It is her death in a custodial setting that is so keenly and painfully felt by her family. She ought to have had the possibility of seeking and obtaining the comfort and assistance of her friends or her family if she had been able to sense her deterioration that night.

315. Ms Mandijarra was deprived of her liberty. Her detention was lawful. The police's evidence was that they took account of her own safety as one of the factors supporting her detention. However, for her family the felt trauma of her death in custody following an arrest for low level offending is not ameliorated by the suggestion that after arrest she was then detained in a cell at the Lock-up for her own safety.

IMPROVEMENTS SINCE MS MANDIJARRA'S DEATH

316. Since Ms Mandijarra's tragic death there have been improvements in the areas of monitoring of a detainee's welfare, the use of arrest as a last resort for street drinking, and the allocation of additional resources for Broome Police station.

317. A number of the procedural improvements at lock-ups were implemented as a result of the IAU recommendations following their investigation.

Changes to frequency of cell checks

318. The evidence at the inquest established that the intervals between physical cell checks for Ms Mandijarra were too long.

319. The WAPOL Manual has since introduced a more rigorous regime for cell checks.[142] LP-10.01 now provides guidance as to the time intervals for cell checks. Under normal conditions (being where the detainee is not classified as "*high risk*") they are as follows [extract]:

> *"Cell welfare checks must be performed every 20 minutes within the first hour and then at least every hour after that".*

320. In the case of a detainee that is classified as "*high risk*" the cell check requirements are specified in clear and exacting terms, as follows [extract]:

> *"In addition to these cell welfare checks, detainees who are considered 'high risk' must be monitored continuously for the first 30 minutes, then monitored every 10 minutes."*

321. The above regime continues unless and until a supervisor has determined that the grounds for the "*high risk*" assessment do

[142] Exhibit 3, tab 23

not present a current risk. In that case, the cell check requirements revert to the normal intervals.

322. The guidance in respect of time intervals reinforces the importance of maintaining contact with detainees, in order to address safety and welfare needs.

Integration of Custody database and IMS

323. The evidence at the inquest established that at the time of Ms Mandijarra's admission to custody, the police officer populating the data fields on the Custody system did not separately check all of the "*Warnings*" and "*Alerts*" for Ms Mandijarra on the IMS system.

324. The IAU review identified a need for the Custody system database to be aligned with the IMS system so that "*Warnings*" and "*Alerts*" on the IMS system are pre-populated into the Custody database.

325. This recommendation has been implemented through the new Custodial Management Application.

326. This allows the police officers responsible for the detainee's safety and welfare to more comprehensively access any available and relevant information regarding a detainee. It better informs the police officer responsible for assessing the risk level of a detainee. Cell checks can then be adapted as appropriate for the individual detainee.

Assessment of High Risk detainees

327. The evidence at the inquest established that the police officer responsible for Ms Mandijarra's welfare overnight was under the impression that once she was asleep, she was no longer to be regarded as a "*high risk*" detainee, despite that classification remaining on the Custody system.

328. His belief was formed in part because the existing entry on the Custody system reflected that Ms Mandijarra was at increased risk due to her intoxication and agitation. He formed the view that the risk was associated with her behaviour (as opposed to her health and welfare) and he assumed that she was longer to be managed as "*high risk*" once she was asleep.

329. As outlined above, the integration of the Custody database with IMS will provide for the transmission of more comprehensive information when a detainee is admitted into custody.

330. In addition the WAPOL Manual now makes it clear, at LP-04.03, that a detainee should be considered "*high risk*" if one or more of a number of factors apply, including if the detainee:

a) has been or is a self-harm risk;
b) has or is known to have had serious health issues.

331. Both of these factors applied to Ms Mandijarra and she ought to have been managed as a "*high risk*" detainee throughout the period of her detention. At the very least it would have mandated far more frequent physical cell checks for her.

Welfare screening to be ongoing

332. The evidence at the inquest established that after Ms Mandijarra was taken to Cell 4 at approximately 7.15 pm, having refused to answer the questions at her welfare screening, she was not re-questioned regarding her welfare. The admission to custody proceeded in the absence of those answers and in accordance with established procedure.

333. It cannot now be known whether, if re-questioned, Ms Mandijarra might have volunteered information that reflected upon her health and welfare needs, or the interpretation of her risk assessment.

334. The WAPOL Manual now makes it clear, at LP-04.14, that as part of a welfare screening, where a detainee refuses to answer, or only partly answers, welfare questions, every endeavour should be made to requestion the detainee at the earliest opportunity.

Changes to "batch" checking

335. The evidence at the inquest established that a separate record of how the police officer specifically determined Ms Mandijarra's welfare following each cell check was not made.

336. The WAPOL Manual now makes it clear, at LP-10.03, that after a cell check the police officer must make a separate record of the observations made for each detainee by the addition of the following words: "*....including how they determined the welfare of the detainee, i.e. spoken to, observed rise and fall of chest or other observation.*"

337. Compliance with this requirement will avoid the "*batch*" checking and recording undertaken by Senior Constable Colman when Ms Mandijarra was detained at the Lock-up. He was responsible for the welfare of seven detainees and on each occasion he entered details to the following effect: "*Detainees sleeping, all appears correct.*"

338. At the inquest Senior Constable Colman attributed this practice to the heavy workload at the material time: "*It was more efficient to select everyone, and abbreviate by saying that there were no issues and everything was correct, that I – I had no concerns for anyone's welfare.*"[143] This practice was common at the Lock-up at the material time, and not unique to Senior Constable Colman.

339. It would have been particularly relevant to know Senior Constable Colman's observations of Ms Mandijarra during his physical cell check at 2.24 am on 30 November 2012. Whilst I have accepted, on all of the evidence before me, that Ms Mandijarra most likely survived beyond that time, in the absence of a specific record, I cannot now determine what signs of life he observed at 2.24 am.

340. At the material time, the Custody system allowed for police officers to place their observations in one entry for multiple Custody episodes when they undertook cell checks for a number of detainees. On 8 June 2013 an instruction was issued to all police officers in the Kimberley region that this practice of "*batch*" checking was to stop.[144]

341. Since that time, the Custodial Management Application has been redesigned. In relation to cell checks, a user can select a cell, cell block or facility to undertake "*batch*" checking. This will present a list of detainees in the group on the one page. However the user is required to select or enter information that is specific to each detainee. It is no longer possible to select one response/observation and apply it generically

[143] ts 274
[144] Exhibit 2, tab 1

across the group. In other words, it is no longer possible to undertake "batch" recording.

Changes to modality of physical cell check

342. The evidence at the inquest established that a number of the cell checks for Ms Mandijarra were undertaken remotely, through the CCTV camera.

343. The WAPOL Manual now also makes it clear, at LP-10.03, that CCTV is not adequate to determine the rise and fall of the chest. This is an important improvement. I am not satisfied that CCTV allows for a proper appraisal. The matter is now put beyond doubt as far as the procedures are concerned.

344. The WAPOL Manual gives guidance on how welfare is to be addressed, in a manner that is appropriate for each detainee, having regard to past history, if known, and the information available and assessment made at the time of admission to custody.

345. The intent is to encourage interaction where appropriate with the detainee, so that safety, welfare and reasonable needs may be more properly ascertained through direct observation and discussion, if appropriate. This cannot be achieved though CCTV vision.

346. The Broome Manual had always required the police officer to physically visit the Lock-up.

Increased number of police officers in Broome

347. The evidence at the inquest established that at the material time the officers at Broome Police Station had multiple tasks to attend to, there was no dedicated Lock-up keeper position and it was therefore difficult to comprehensively comply with the cell check requirements of the Broome Manual.

348. When Senior Sergeant Barwick assumed his role as officer-in-charge of Broome Police Station in March 2013, he did not consider that the cell check requirements of the Broome Manual could be complied with either, due to workloads, staff numbers and the need to prioritise duties and roles.[145]

[145] ts 226

349. Since that time, the WAPOL Manual was amended as outlined above (including the more rigorous cell check procedure) and reissued in August 2014 for state-wide implementation, thereby facilitating consistency of approach.[146]

350. At the inquest Senior Sergeant Barwick informed the court that in November 2015, a further 15 staff members were allocated to Broome Police Station. As the additional staff members became available, he was able to establish a dedicated Lock-up keeper position, to be filled on a 24 hour seven day a week basis on every shift when a person is in custody. This person is not charged with any duties other than those of Lock-up keeper.[147]

351. I am informed that Broome Police Station has two male and two female Aboriginal staff members. This together with the dedicated Lock-up keeper position should assist with communication with detainees in similar circumstances.

Reduction in incarceration rate of intoxicated detainees

352. The evidence at the inquest established that at the material time Senior Sergeant Van Der Ende's zero tolerance approach did not instruct arrests for street drinking. Police officers were still to use their discretion when deciding whether to exercise the power of arrest in individual cases. However, when considered together with the flow chart, the zero tolerance policy ultimately resulted in the more frequent exercise of the discretion to arrest and detain a person for street drinking.

353. When Senior Sergeant Barwick assumed his role as officer-in-charge of the Broome Police Station in March 2013, he retained the zero tolerance approach in relation to unlawful activity. However, this was moderated by his policy of arrest being the last resort after every other appropriate option was exhausted.[148]

354. At the inquest Senior Sergeant Barwick outlined the application of his policy of arrest as a last resort. He has achieved a decrease in the number of persons being admitted to the Lock-up by means that have included the reduction in

[146] ts 225 - 227
[147] ts 230
[148] ts 220 - 224

the exercise of the power of arrest in the case of simple offences such as disorderly and threatening behaviour, street drinking and minor assaults. Alongside this approach, in the case of an arrest, bail is to be considered immediately, or within a reasonable time.[149]

355. Senior Sergeant Barwick informed the court that where there is an outstanding warrant for arrest or commitment in respect of a relatively simple offence Broome police will endeavour to engage with Aboriginal police liaison officers or community relations officers to arrange an arrest by appointment during daylight hours so that the person may be properly conveyed to court or to the prison, as required. In the case of an arrest for a non-violent breach of a Violence Restraining order, police will consider the appropriateness of bail with protective conditions.[150]

356. Senior Sergeant Barwick's approach is to be commended, as recognised by the ALS in its submission. At the inquest he readily indicated that the alternate approach is undesirable and it is evident that he has a role in training Broome police on the use of the arrest power as a last resort:

> *"So we've implemented a whole lot of non-custodial services that I want in the lockup, and hard – it's hard to communicate to the staff who can see it as a soft option on occasions, that these people are committing offences and they should be brought to justice. But, ultimately, we can end up in a position like this for a relatively minor offence."*[151]

357. Under s 12 of the Protective Custody Act, as soon as practicable after an adult is apprehended under this legislation s/he is to be released into the care of another person or appropriate facility. Detention at the Lock-up is only to occur in exceptional circumstances, or where it is impractical to comply with the alternatives by taking reasonable measures.

358. In November 2014 the Acting Deputy Commissioner (Operations) issued a Broadcast to officers-in-charge of regional Western Australian Police Stations in connection with "*Protective Custody of Drunk Detainee's* (sic)". The November 2014 Broadcast instructed that lodging uncharged persons in a lock-up under the Protective Custody Act, based on level of

[149] ts 220 – 224; ts 246
[150] ts 246
[151] ts 247

intoxication, should only occur as a last resort, and all other options were to be exhausted.[152]

359. The November 2014 Broadcast instructed officers-in-charge to: *"carefully consider the fitness for custody of all 'drunk detainees' and consider local arrangements for assessments to be undertaken when required."* By way of example it was outlined that at Perth Watch House all "*drunk detainees*" are to be assessed as fit for custody initially by the nurse on duty. If the nurse is not available, the detainee is to be assessed at hospital.[153]

360. The Protective Custody Act was not utilised for Ms Mandijarra's detention. However, the considerations outlined in the November 2014 Broadcast are relevant to Ms Mandijarra's circumstances, as it was her intoxication and repeated behaviour at Male Oval that precipitated her arrest.

361. Instructions to similar effect as the November 2014 Broadcast were reiterated by Senior Sergeant Barwick to all staff at Broome Police Station in February 2016, in the form of a reminder, and they were broadened to include not only apprehensions under the Protective Custody Act, but also certain arrests. Senior Sergeant Barwick instructed that detaining persons in the Lock-up is the last resort, unless there is a legislative requirement, or other contributing factor, such as the continuance of offending, or a serious offence. His instruction included the following: "*if we come across intoxicated persons who need to be detained for their own safety then, please utilise the services of Kullari, sober up shelter, family, friends….first, incarceration in the lock-up is the last resort.*"[154]

362. At the inquest I received into evidence statistical information regarding the number of persons admitted at Broome Police Station between 1 January 2011 and 31 March 2016, that reflected the following:

a) a marked and continuing decrease in the overall number of persons admitted for offences related to intoxication after 2012;

b) a marked decrease in the overall number of persons detained under the Protective Custody Act after 2011,

[152] Exhibit 5, tab 9
[153] Exhibit 5, tab 9; ts 221 - 223
[154] Exhibit 5, tab 10

with a substantial decease after 2013, continuing to the point where no such person was detained in 2015, nor for the period in 2016.[155]

363. Those same statistics also showed that in most years, Aboriginal persons constituted the majority of persons admitted at Broome Police Station for offences related to intoxication, or detained under the Protective Custody Act.

364. The concerns expressed in the RCIADIC about detaining Aboriginal persons for the non-criminal activity of public drunkenness over 20 years ago were borne out in the case of Ms Mandijarra's detention.

365. The RCIADIC had recommended the abolition of the offence of public drunkenness, to be accompanied by adequately funded programs to establish non-custodial facilities for the care and treatment of intoxicated persons.[156]

366. In Western Australia this gave rise to the establishment of the Broome Sobering-up Shelter (and eight other shelters across the State).[157] Unfortunately Ms Mandijarra had been banned from the Broome Shelter for a period of time, due to her non-compliant behaviour there. Given the extent of Ms Mandijarra's intoxication on the evening of 29 November 2012, a hospital setting would have been more appropriate for her in any event.

367. The RCIADIC also recommended that arrest be a sanction of last resort, as one of the means of reducing the number of Aboriginal persons held in custody. Of the 99 cases of deaths in custody that the RCIADIC considered, 35 of the individuals had been detained for public intoxication and eight of those 35 had been detained in jurisdictions where public drunkenness was not an offence.[158]

368. It is no doubt helpful that various instructions have been issued to police by way of Broadcast or email regarding the need to consider alternatives to apprehension and detention under the Protective Custody Act, and/or arrest and detention in connection with street drinking. Information has also been circulated regarding the need for an intoxicated detainee to receive an appropriate health assessment.

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[155] Exhibit 5, tab 19.2
[156] RCIADIC recommendations 79 and 80; RCIADIC National Report, (1991), paragraph 32.1.2
[157] In addition to Broome, there are sobering up shelters in Derby, Kalgoorlie, Kununurra, Perth, Port Hedland, Roebourne, Wyndham and Geraldton
[158] RCIADIC recommendation 87; RCIADIC National Report (1991), Volume 1: 2.4.1 to 2.4.2

369. The more widely distributed November 2014 Broadcast is confined to apprehensions under the Protective Custody Act. The February 2016 instructions incorporating arrest as a last resort apply to Broome police and were not issued state-wide.

370. In order to more completely reinforce this approach and to more broadly disseminate it state-wide, I make recommendations numbered 2 to 4 below. However, my first and primary recommendation concerns a threshold issue, namely whether the legislation enabling the arrest and detention of a person for street drinking (where no other criminal activity is suspected) ought to be reviewed and reconsidered.

371. At present, a person who is found to be street drinking, in circumstances where the police officer reasonably suspects that if the person is not arrested, the person will continue (or repeat) the offence, that person may be arrested and detained in a lock-up until sufficiently sober to be released to bail.

372. Granted these legislative provisions would not frequently be utilised, the fact is that they were invoked in Ms Mandijarra's case. In the circumstances of street drinking, the degree of reasonable suspicion that the police officer needs to have is not readily amenable to review, and it could run the risk of arbitrary application.

373. Whilst the maximum penalty for street drinking under the Liquor Control Act is $2,000, once it is reasonably suspected of continuing unless the person is arrested, it becomes subject to arrest and detention. It is to be borne in mind that there is already a pathway for addressing disorderly behaviour in a public place. Under s 74A of the Criminal Code (WA), the person is guilty of an offence and liable to a fine of $6000.

374. I therefore recommend that Parliament consider the abolition of arrest and detention for street drinking. In the alternative, that arrest and detention for street drinking be a last resort (see recommendations 1 to 3 below). I also recommend that the need for a health assessment for an intoxicated detainee be reinforced and embedded in the WAPOL Manual as part of considerations for admission to custody and detention in a lock-up (see recommendation 4 below).

RECOMMENDATION 1 – ABOLITION OF ARREST AND DETENTION FOR STREET DRINKING

I recommend that Parliament consider the abolition of the power to arrest and detain an intoxicated person for street drinking where the police officer reasonably suspects the person will continue street drinking unless the person is arrested.

RECOMMENDATION 2 – ARREST A LAST RESORT FOR STREET DRINKING

As an alternative to Recommendation 1, I recommend that arrest of an intoxicated person under s 119(1) of the Liquor Control Act 1988, read together with s 128(3) of the Criminal Investigation Act 2006, for street drinking, be a last resort.

RECOMMENDATION 3 – DETENTION A LAST RESORT FOR STREET DRINKING

I recommend that the WAPOL Manual be amended to specify that detention in a lock-up be a last resort in cases where an intoxicated person is apprehended under the Protective Custody Act 2000 in order to protect their health or safety, or arrested under the Liquor Control Act 1988, read together with section 128(3) of the Criminal Investigation Act 2006, for street drinking.

375. At the inquest Sergeant Kendall confirmed that there is no ongoing arrangement for a nurse (or other health clinician) to visit the Lock-up, and no arrangement whereby intoxicated persons admitted to the Lock-up are seen by a health clinician at the Lock-up.[159]

376. Intoxication is not of itself a criminal justice issue, nor should it be seen as merely a social issue. It is primarily a health issue. In the case of an incarceration, there are potentially severe ramifications if an intoxicated person falls asleep and remains unmonitored. Depending on the level of intoxication and the effects on the person, these can range from cardiac arrhythmia due to alcohol toxicity, positional airway

[159] ts 114

obstruction leading to the cessation of breathing, aspiration of vomitus, and/or seizure. All of these can result in death.

377. The risk involved in detaining a heavily intoxicated person in a lock-up, particularly overnight, is not to be underestimated. The assessment of the likely effects of intoxication on a person's general health ought not be left to police officers. A health assessment is required. A clinician is also able to take account of other relevant health conditions that may be exacerbated by the intoxication.

378. The November 2014 Broadcast by the Deputy Commissioner (Operations) drew attention to the need for police officers to consider health assessments for intoxicated detainees. Whilst the Perth Watch House has a duty nurse, regional centres were instructed to carefully consider the need for heath assessments. I therefore make the following recommendation:

RECOMMENDATION 4 – HEALTH ASSESSMENT FOR INTOXICATED DETAINEES

I recommend that the WAPOL Manual be amended to provide that a welfare screening of an intoxicated person for the purpose of admission to custody in a lock-up is not complete unless the person has had a health assessment by a nurse, or if a nurse is not available and present, a health assessment at the hospital. This is particularly important in the case of a proposed overnight detention.

EXTANT RECOMMENDATIONS

379. I take account of the fact that there is now a dedicated Lock-up keeper for Broome. There is therefore no need for me to make a recommendation to this effect in respect of the Lock-up at Broome.

380. A number of extant recommendations that I have made apply equally to Ms Mandijarra's case, to avoid deaths arising in similar circumstances, and not necessarily confined to Broome. They are made in connection with my findings on inquest into the death of **Ms Dhu using the numbering in that finding** (47/15) as follows:

- **<u>Recommendations 1 and 2 – in connection with dedicated lock-up keepers and mandatory training on their roles and responsibilities</u>;**

  I recommend that at every police station where detainees are held, there must be a dedicated lock-up keeper. Alternatively that a minimum of two officers are rostered for custodial care duties at any time.

  I recommend that a mandatory training course on the roles and responsibilities of lock-up keeper/supervisor be developed and introduced across Western Australia and that a component of the training be undertaken face-to-face. Successful completion of the course ought to be mandatory before an officer can be assigned lock-up keeper/supervisor duties.

- **<u>Recommendations 3 and 4 – in connection with the development of the Western Australia Police Service's cross-cultural diversity training</u>;**

  I recommend that the Western Australia Police Service develops its cross-cultural diversity training to address the following:

  1. *That there be mandatory initial and ongoing cultural competency training for its police officers to assist in their dealings with Aboriginal persons and to understand their health concerns;*
  2. *That Aboriginal persons be involved in the delivery of such training;*
  3. *That successful trainees should be able to demonstrate cultural competency – that is a well-developed understanding of Aboriginal issues and the skills to deal effectively with Aboriginal communities; and*
  4. *That the initial training and at least a component of the ongoing training is to be delivered face-to-face.*

  I recommend that the Western Australia Police Service develops its training for police officers who are transferred to a new police station to address the following:

  1. *That it be a standard procedure for all police officers transferred to a location with a significant Aboriginal population to receive comprehensive cultural competency*

training, tailored to reflect the specific issues, challenges and health concerns relevant to the location;

2. *That members from the local Aboriginal community be involved in the delivery of such training, and that it be ongoing to reflect the changing circumstances of the location; and*
3. *That the initial training and at least a component of the ongoing training is to be delivered face-to-face.*

- **Recommendation 5 – in connection with the provision by medical clinicians to police of sufficient medical information to manage a detainee's care while in police custody;**

  I recommend that Parliament consider whether legislative change is required in order to allow medical clinicians to provide the Western Australia Police Service with sufficient medical information to manage a detainee's care whilst in police custody. Allied to this is a consideration of the safeguards concerning that information.

- **Recommendation 9 - in connection with police contacting the Aboriginal Visitors Scheme once a decision has been made to detain an Aboriginal offender in a lock-up, and/or take an Aboriginal detainee for medical treatment;**

  I recommend that a policy be introduced by the Western Australia Police Service that requires the police to contact by telephone the Aboriginal Visitors Scheme once a decision has been made to detain an Aboriginal offender in a police lock-up. In addition, any APLO attached to the station should also be made aware by police that they may contact the Aboriginal Visitors Scheme at any time on behalf of a detainee.

  Furthermore, once a decision has been made to take an Aboriginal detainee for medical treatment, contact by telephone must be made by the police to the Aboriginal Visitors Scheme advising it of that fact, the name of the detainee and which hospital or medical treatment facility the detainee is being taken to.

- **Recommendation 10 – in connection with consideration of the introduction of a Custody Notification Service;**

  I recommend that the State Government gives consideration as to whether a state-wide 24 hours per day, seven days per

week Custody Notification Service based upon the New South Wales model ought to be established in Western Australia, to operate alongside and complement the Aboriginal Visitors Scheme.

- **Recommendation 11 – in connection with amendments to the WAPOL Manual in relation to the care of detainees, to assist with better recognising risk factors.**

  I recommend that the lock-up procedure manual be amended to make reference to the following in relation to the care of detainees:

  - *A greater degree of regular monitoring should be provided to any detainee complaining of severe symptoms that necessitate repeated hospital attendances within a short space of time;*
  - *New or changing symptoms in an unwell detainee may signify deterioration warranting medical review;*
  - *Drug and alcohol use are risk factors for serious illness, and can both mimic and obscure the symptoms of serious illness; and*
  - *A person found to be unconscious or not easily rousable whilst in police custody must be immediately conveyed to hospital by ambulance.*

CONCLUSION

381. Ms Mandijarra's death in the Lock-up when she was in the control, care and custody of the police re-enlivens the trauma of Aboriginal deaths in custody, and calls into question the adequacy of the steps that have been taken to avoid such deaths. Ms Mandijarra's death occurred just over 20 years after the RCIADIC, in circumstances where the arrest and detention of Aboriginal persons for public drunkenness had then been identified as a concern.

382. In November 2012, Ms Mandijarra was unwell, homeless and exposed to risks of assaults and of self-harm. She was unable to adequately self-care or curb her consumption of alcohol. This accumulation of factors could not have been addressed by any one entity or agency. She needed a multi-party inter-sectoral response aimed at ameliorating the social determinants of her ill health and treating the various facets of her physical diseases and her alcoholism.

383. Ms Mandijarra's decision not to engage with a primary health care centre meant that there were missed opportunities for clinicians to commence a holistic approach to her health needs, and underscores the degree of her impairment. Unfortunately by 2012 her options were becoming very limited and her street drinking drew her to the attention of police on a number of occasions. Looking back, it is clear that arrest and detention was not the answer.

384. This inquest highlighted the risks posed by detaining a heavily intoxicated person in a lock-up, particularly overnight. It also drew attention to the undesirability of detention in a lock-up for street drinking where no other criminal activity is identified or suspected. There is a risk that under some circumstances, such arrests and detentions may impact disproportionally upon Aboriginal persons.

385. It is my hope that the recommendations I have made will assist in reducing the overrepresentation of Aboriginal persons in lock-ups, particularly in regional areas and certainly where the only reason is based upon the street drinking behaviour.

R V C FOGLIANI
STATE CORONER
31 March 2017